Principal Investigator name, Hospital name
Hospital address
Telephone contact number, email for PI

CONSENT FORM FOR THE PATIENT'S REPRESENTATIVE

THE WOMAN TRIAL

Title of Research: Tranexamic acid for the treatment of postpartum haemorrhage: An international randomised, double blind, placebo controlled trial

Hospital code number		Name of Local Principal Investigator									
Patient Hospital ID Number			Randomisation Number								
						BOX				PACK	
Name of Patient											
Name of Representative			Relationship of representative to patient								

Version Number: 1.0 / Version Date: 11 May 2009

PLEASE INITIAL BOXES

1. I confirm that I have read and understood the information sheet Version Number_____, version date_____, for the above study and have had the opportunity to ask questions. ☐
2. I confirm that I am not aware of any reason why this patient would have objected to taking part in this study. ☐
3. I understand that my consent is voluntary and that I am free to withdraw it at any time without giving any reason and without the patient's medical care or legal rights being affected. ☐
4. I understand that sections of the patient's medical notes and those of her baby/ies may be looked at by responsible individuals involved in the study. ☐
5. I give permission for a copy of this consent form which contains my personal information to be made available to the Trial Coordinating Centre in London for monitoring purposes only. ☐
6. I give permission for the patient's personal doctor to be given information about her participation in this trial. ☐
7. I agree for the above named patient to take part in the WOMAN trial. ☐

_____ _____
Signature / thumbprint or other mark of Representative (if unable to sign) Date

_____ _____ _____
Name of person taking consent Date Signature

_____ _____ _____
Name of local principal investigator Date Signature

(Witness only if required) The representative is unable to sign and as a witness I confirm that the representative has been given all the information about the trial and has verbally consented to taking part.

_____ _____ _____
Name of witness Date Signature

Original to be filed in the Investigator's Study File, 1 copy for representative, 1 copy to be kept with woman's hospital records