a place of mind

H11-01995 Cerebral Palsy: Causes to Prevention - Phase 1: The Canadian Cerebral Palsy Registry - BC Division

Principal Investigator: Dr. Esias van Rensburg MB.Ch.B; FRCPC, Sunny Hill Health Centre – UBC
Contact Phone Number: 604-453-8300

Please fax completed form to:
Diane Wickenheiser, BC Research Coordinator for Canadian CP Registry: 604-453-8301

Purpose:
This form is to provide consent for a member of the study team to contact you for the purpose of providing further information about the Canadian Cerebral Palsy Registry and to ask for you and your child's participation in the study.

Background:
Our research team has shown that there is a need to create a Canadian Cerebral Palsy Registry to gain a better understanding of incidence, prevalence and distribution of Cerebral palsy in different regions across Canada. By looking at this information across different regions, it may help determine different risk factors and causes associated with this condition and potentially this information can be used to improve the overall care for this population. **Completion of this form does not provide consent to participation in the study.** You do not need to provide your contact information at all. You are free to withdraw your contact information at any time by calling the study coordinator and requesting removal of your information. You do not need to provide any reason for your decision. No one will be upset with you. Your child's medical care will not be affected in any way.

Authorization:
By signing this consent I authorize ______________________________ (name of health care provider) to collect and release the following information to the study investigators and coordinator. By signing this consent form I give permission to the study team, or designate, to contact me for the purpose of providing further information about this study and to be asked to participate in the study. I understand that I am free to withdraw this information at any time, without having to give a reason and without affecting my child's future medical care.

Please complete the information you consent to release to the study investigators and coordinator:

Child's Name: ___________________________ Parent's Name: _________________________________

Phone Number: _________________________ Alternate Number: __________________________________

Address: _______________________________ City: _____________________ Postal Code _____________

Email Address: __________________________

Consent is effective starting ________________ (date) and expires April 30, 2019.

Please select type of consent:

☐ **Parent Verbal Consent**: If yes: Name of Child Health Professional: _______________________

Phone Number: _______________________ Signature of Child Health Professional: ____________________

☐ **Written Consent (please fill out below)**

_____________________________ _____________________________ _____/_____/_____
Signature of Parent or Guardian Name (Printed) Year Month Day

_____________________________ _____________________________ _____/_____/_____
Signature of Person obtaining consent Name (Printed) Year Month Day