British Hernia Society Registry (BHSR) Consent Form

PATIENT DETAILS or PATIENT STICKER	
First Name:	**Surname:**
Date of Birth:	**NHS number:**

What information do we collect routinely?
We collect some basic details about your operation (including any implant used) and your health.

Why do we ask to collect your personal and contact information?
We want to link these basic details securely to your personal details so we can contact you to see how you are after your operation. This also allows your details to be securely linked to any future details about you in the Registry, either entered by you (if you consent to follow-up), a surgeon or imported from another database. We collect this information to audit operations and results of surgeons, hospitals, and implants, and to perform ethically approved research to improve results for patients. You cannot be identified from any reports or research.

1. PERSONAL DETAILS CONSENT

I CONSENT / DO NOT CONSENT to my personal details being recorded within the Registry.

I UNDERSTAND THAT:

- My personal details will not be released, unless required by law, or where there is a clear overriding public interest in disclosure. If possible, I will be told if any disclosure is to take place.
- These and future details can be securely linked to other approved health databases.
- Non-identifiable information may be used by researchers to improve patient care, and to audit results of surgeons, hospitals and implant manufacturers, and I cannot be identified by this.
- I can request to look at the data recorded about me at any time, and ask for my personal or contact details to be deleted.
- I will not have any rights, financial or otherwise, to any outputs from the registry.

Patient Signature: **Date:**

2. CONTACT DETAILS CONSENT FOR PATIENT REPORTED OUTCOMES (SURVEYS)

I CONSENT / DO NOT CONSENT to my personal details being recorded within the Registry.

- I understand that these contact details will not be released to any third party and will only be used to contact me to ask about my care and treatment.

Patient Signature: **Date:**

Email address: **Mobile Tel. Number:**

RESPONSIBLE PROFESSIONAL ACCEPTING PATIENT CONSENT:

Name: **Position:**

Date: **Place:**