







P15224.01/P16198.01 OFFICE COPY ADULTS 16+

NATIONAL DIET AND NUTRITION SURVEY Y14/Y15

CONSENT FORM: Linking survey answers to other information (ENGLAND)

The National Health Service (NHS) maintains medical and health records on all patients who use their services, such as:

- In-patient and out-patient visits to hospital, length of stay and waiting times
- Information about specific medical conditions such as cancer
- Details about when people pass away, the date and cause of their death.

The National Diet and Nutrition Survey has been running since 2008 and provides valuable information on what people eat and how this may affect their health. We would like to ask for your permission to add information from some medical and health records to the answers you have provided in the survey. The information we would like to add is from the

Hospital Episodes Statistics data, civil registration mortality data and Cancer Registration data (held by the appropriate governing body, currently NHS Digital). To link this information we need to send your name, address and date of birth to NHS Digital so they can identify your health records, and your health records would then be linked to the anonymised survey data, using a unique ID.

NHS Digital will provide the Hospital Episodes Statistics data, the civil registration mortality data and the Cancer Registration data.

By linking this information we can look at how a person's lifestyle can have an impact on their future health. For example, if a person who took part in the National Diet and Nutrition Survey gets cancer or dies, the type of cancer or cause of death will be linked with their answers to the survey.

As we would like to look at long term trends in people's health, we have not set a limit on how long we will keep your information.

This information will be used for statistical and research purposes only. The information will not identify you and it cannot be used by anyone treating you as a patient.

By signing this form you are only giving permission to link survey information to administrative health data (as detailed above), and nothing else. We will <u>not</u> be able to obtain any other details from your medical records.

You can cancel this permission at any time in the future by writing to: **NatCen Social Research, 35 Northampton Square, London EC1V 0AX**, or you can telephone: 0800 652 4572. You do not need to give a reason to cancel this.

For further information please visit: www.natcen.ac.uk/taking-part/studies-in-field/national-diet-and-nutrition-survey

Your consent:	Please tick	
consent to my survey answers being linked	to:	
Hospital Episodes Statistics data		
Civil registration mortality data		
Cancer registration data		
understand that information held and mana	ged by NHS Digital may be used in orc	ler to provide information about my
understand that these details will be used f	or statistical and research purposes on	ly.
Participant signature	Participant name	 Date
nterviewer signature	 Interviewer name	 Date









P15224.01/P16198.01 PARTICIPANT COPY ADULTS 16+

NATIONAL DIET AND NUTRITION SURVEY Y14/Y15

CONSENT FORM: Linking survey answers to other information (ENGLAND)

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As we would like to look at long term trends in people's health, we have not set a limit on how long we will keep your information.

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For further information please visit: www.natcen.ac.uk/taking-part/studies-in-field/national-diet-and-nutrition-survey

Your consent:	Please tick	
consent to my survey answers being linked	to:	
Hospital Episodes Statistics data		
Civil registration mortality data		
Cancer registration data		
understand that information held and mana	ged by NHS Digital may be used in orc	ler to provide information about my
understand that these details will be used f	or statistical and research purposes on	ly.
Participant signature	Participant name	 Date
nterviewer signature	 Interviewer name	 Date









OFFICE COPY

National Diet and Nutrition Survey

NDNS) Spot Urine Sample	STICK BARCODE	
DULT CONSENT FORM (16+ years)	LABEL HERE	
IREC Reference Number: 13/EE/0016		
lease use capital letters and write in ink		

SERIAL NUMBER	CHECK LETTER	PERSON No.	SEX
			MALE
SERIAL NUMBER			FEMALE
D D M M Y Y			
I confirm that I have read and understal information sheet(s) dated 05.02.2020 the above study. I have been given the had these answered satisfactorily.	(version 5)/ 01.12.20	21 (version 5.1) for	Please initial (or tick) boxes
2. I understand that my participation is vo from the study at any time without givin or legal rights being affected.	•		
3. I consent to provide a urine sample for	the measurement of	lodine.	
4. I give permission for any remaining uring and used in future research with neces	•	•	
Name of Participant (Please print)	Date	 Signature	
Name of Interviewer (Please print)	 Date	 Signature	

When completed: bottom copy for participant; top copy for NatCen office

You can cancel this permission at any time in the future by writing to us at the following address: NatCen Social Research, 35 Northampton Square, London EC1V 0AX. Telephone: 0800 652 4572









PARTICIPANT COPY ADULTS 16+

National Diet and Nutrition Survey (ND

(NDNS) Spot Urine Sample	STICK BARCODE
ADULT CONSENT FORM (16+ years)	LABEL HERE
MREC Reference Number: 13/EE/0016	

Please use capital letters and write in ink			
SERIAL NUMBER	CHECK LETTER	PERSON No.	SEX
			MALE
SERIAL NUMBER			FEMALE
D D M M Y Y			
I confirm that I have read and understar information sheet(s) dated 05.02.2020 (the above study. I have been given the had these answered satisfactorily.	version 5)/ 01.12.2021	(version 5.1) for	Please initial (or tick) boxes
2. I understand that my participation is vol from the study at any time without givin or legal rights being affected.	•		
3. I consent to provide a urine sample for	the measurement of lo	odine.	
4. I give permission for any remaining uring and used in future research with necess	•	-	
Name of Participant (Please print)	Date	 Signature	
Name of Interviewer (Please print)	Date	Signature	

When completed: bottom copy for participant; top copy for NatCen office

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FOR POST OFFICE (COOL BOX) DELIVERY PROTOCOL

	Please use capital letters and write in ink	INDIVIDUAL SERIAL Please write in below		CHECK LETTER	PERSON NO.
	ADDRESS	N LABE (If pr	TICK CON L HERE oviding sample)		
1.	Nurse number: 2. Date schedule completed (all visits complete):	DAY: MONTH	YEAR:		
3.	Full name (of person tested)				
	Name by which GP knows person (if different)				
4.	Sex Male 1 Female 2 5. Date of birth:	DAY: MONTH	YEAR:		
_					
6.	Full name of parent/guardian (if person under 16)				
 7. 	GP NAME AND ADDRESS (Please complete fully)	NURSE US	E ONLY		
			ress comple	1	
	GP NAME AND ADDRESS (Please complete fully) Dr:	GP Address	ress comple not comple	te 2	
	GP NAME AND ADDRESS (Please complete fully) Dr: Practice Name: Address:	GP Address	ress comple	te 2	
	GP NAME AND ADDRESS (Please complete fully) Dr: Practice Name: Address: Town:	GP Address	ress comple not comple	te 2	
	GP NAME AND ADDRESS (Please complete fully) Dr: Practice Name: Address:	GP Address	ress comple not comple	te 2	
	GP NAME AND ADDRESS (Please complete fully) Dr: Practice Name: Address: Town: County:	GP Address	ress comple not comple	te 2	
	GP NAME AND ADDRESS (Please complete fully) Dr: Practice Name: Address: Town: County: Postcode:	GP Address	ress comple not comple	te 2	

Nurse: Please confirm whether a blood sample was obtained?

YES NO

BLOOD SAMPLE LIST

The tables below show which blood samples should be taken (in priority order) and need to be sent to the lab for each age group:

PARTICIPANTS AGED 16+

Priority	Blood Tube	Colour	Label Reference
1	EDTA K3 2.0 ml	Lilac	EN1
2	Serum TE 6.0 ml	Royal Blue	SEN1
3	Li Hep LH 6.0 ml	Green	LHN1
4	Serum TE 6.0 ml	Royal Blue	SEN2
5	Li Hep LH 6.0 ml	Green	LHN2
6	EDTA K3 4.0 ml	Purple	EN2

PARTICIPANTS AGED 7-15

Priority	Blood Tube	Colour	Label Reference
1	EDTA K3 2.0 ml	Lilac	EN1
2	Serum TE 6.0 ml	Royal Blue	SEN1
3	Li Hep LH 6.0 ml	Green	LHN1
4	Serum TE 6.0 ml	Royal Blue	SEN2

PARTICIPANTS AGED 18 mths - 6 yrs

Priority	Blood Tube	Colour	Label Reference
1	EDTA K3 2.0 ml	Lilac	EN1
2	Serum TE 6.0 ml	Royal Blue	SEN1
3	Li Hep LH 4.0 ml	Green	LHN1







National Diet and Nutrition Survey (NDNS) Nurse Visit ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Ple	ase use capital letters and write i	n ink		
				Office copy
SEF	NIAL NUMBER	CHECK LETTER	PERSON NO.	
			I	Please initial/tick poxes if consent given
1.	I confirm that I have read and (s) dated 12.08.2020 (v7.1) / given the opportunity to ask q satisfactorily.	01.12.2021 (v8) for t	he above study. I have bee	
2.	I understand that my participa from any part of the study, at medical care or legal rights be	any time, without giv		
Nam	e of participant (please print)	Date	Signature	
	e of nurse (please print) OOD SAMPLE	Date	Signature	
3.	I agree to have a blood sample	e taken as part of the	study.	
4.	I give permission that my blood and used in future research stu		•	
5.	I would like to receive my blood	d results which are o	linically relevant.	
6.	I consent to my GP being notifie	d of my blood results	which are clinically relevan	t
7.	You will be required to con want to receive your blood re your GP. I confirm that against the advice receive my blood results which my GP. I understand that if the this will not be brought to the acceptance of the second secon	esults <u>AND</u> if you do not be of the NDNS survers are clinically relevance are findings out	ey team, I do not want to vant or have them sent to side of the normal range,	
Nam	e of participant (please print)	Date	Signature	

Signature

Date

Name of nurse (please print)







National Diet and Nutrition Survey (NDNS) Nurse Visit **ADULT CONSENT FORM (16+ years)**

MREC Reference Number: 13/EE/0016

Ple	ase use capital letters and write	in ink		
				Participant copy
SEF	RIAL NUMBER	CHECK LETTER	PERSON NO.	Please initial/tick
				boxes if consent given
1.	I confirm that I have read an (s) dated 12.08.2020 (v7.1) given the opportunity to ask satisfactorily.	/ 01.12.2021 (v8) for t	he above study. I have be	
2.	I understand that my particip from any part of the study, a medical care or legal rights l	t any time, without giv		
Nam	e of participant (please print)	Date	Signature	
Nam	e of nurse (please print)	Date	Signature	
<u>BL</u>	OOD SAMPLE			
3.	I agree to have a blood samp	le taken as part of the	study.	
4.	I give permission that my bloc and used in future research s			
5.	I would like to receive my bloo	od results which are o	linically relevant.	
6.	I consent to my GP being notif	ied of my blood results	which are clinically relevan	t.
7. You will be required to consent to the statement below if you do not want to receive your blood results AND if you do not want them sent to your GP. I confirm that against the advice of the NDNS survey team, I do not want to receive my blood results which are clinically relevant or have them sent to my GP. I understand that if there are findings outside of the normal range, this will not be brought to the attention of any health care provider.				
Nam	e of participant (please print)	Date	Signature	
	e of nurse (please print)	 Date	Signature	







National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (1.5-3 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink										Office copy				
SE	RIAL NUMBER								CHECK LETTER PERSON NO.				D .	
														Please initial/ tick boxes if
Nan	ne o	f Ch	ild	_										consent given
1.	re (v	I am the parent/guardian of the child named above and I confirm that I have read and understand the NDNS Stage 2 information sheet(s) dated 12.08.2020 (v7.1) / 01.12.2021 (v8) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily.												
2.	W	I understand that my child's participation is voluntary and that s/he is free to withdraw from any part of the study, at any time, without giving a reason and without our medical care or legal rights being affected.												
Nam	e of F	Paren	t/Gua	rdian	(plea	se pri	nt)		Date		-	Signature		
Nam	e of n	urse	(pleas	se prii	nt)			-	Date		-	Signature		
BL	00[SA	MPL	<u>.E</u>										
3.	La	agre	e to	my c	hild	havi	ng a	blo	od sa	mple taken	as	part of the stu	dy.	
4.	b	e sto		and								as part of thi ecessary app		′
5.	L	woul	d like	e to	rece	ive n	ny ch	ild's	bloc	od results wh	nich	are clinically	relevant.	
6.			ent t	•	,	ld's (GP b	eing	g noti	fied of his/he	er b	lood results w	hich are	
7.	want them sent to their GP, for us to take a blood sample from your child, you will be required to consent to both of the statements below.													
	()	(i) I confirm that against the advice of the NDNS survey team, I do not want to receive my child's blood results which are clinically relevant or have them sent to his/her GP.												
	(ii) I agree to the survey doctor contacting me to discuss, if necessary, any results that are directly relevant to my child's health.													
Nam	e of F	Paren	t/Gua	rdian	(plea	se pri	nt)		Date		٠ .	Signature		
Nam	e of n	urse	(nleas	se nri	nt)			-	Date		-	Signature		







National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (1.5-3 YEARS)

MREC Reference Number: 13/EE/0016

		use (. NUI	-		ters	and	write			CK LET	TER	DE	De	ON NO.	F	Participant copy
SE	NIAL	NO	VIDEI	`		Ι		1	CHE		ILK	PE	KS 	ON NO.	ь	Naga initial/
Nan	ne o	f Ch	ild			<u> </u>						L			ti	lease initial/ ck boxes if onsent given
1.	l a re (v	am tl ead a /7.1)	he pa and u / 01	ınde .12.2	rstar 2021	nd th (v8)	e NE for t	NS he a	Stag bove	e 2 info study.	ormatio	n shee been	et(s giv	nfirm that I hat s) dated 12.08 ren the oppor y.	ave 8.2020	_
2.	W	ithdr	aw f	rom	any	part	of th	ė stu	ıdy, a	at any t		thout		at s/he is free ing a reason		
Nam	e of F	Parent	t/Gua	rdian	(plea	se pri	nt)	-	Date			Signa	ture	•		
Nam	e of n	urse	(pleas	se prii	nt)			-	Date			Signat	ture	:		
BL	00[) SA	MPL	<u>.E</u>												
3.	L	agre	e to	my c	hild	havi	ng a	bloc	d sa	mple ta	aken as	part o	of th	ne study.		
4.	b		red a	and										of this study y approvals a		
5.	L	woul	d like	e to i	recei	ve m	ny ch	ild's	bloo	d resul	lts whic	h are	clin	ically relevar	nt.	
6.		cons linica		-		ld's (GP b	eing	notif	fied of I	his/her	blood	res	sults which ar	re	
7.	W	ant t	hem	ser	nt to	thei	r GF	, fo	r us	to take	a blo	od sai	mp	AND if you le from your below.		
	(i)	t		ceive	e my	/ chi	ld's	bloo						team, I do no lly relevant c		
	(ii)										me to child's l			if necessary,	any	
Nam	e of F	Paren	t/Gua	rdian	(plea	se pri	nt)	_	Date			Signa	ture)		
Nam	e of n	urse	(nleas	se prij	nt)			_	Date			Signa	ture			



Royal Blue SEN1

LHN1

Green





Blood sample Despatch Form

Nurse number:	Please affix PCB DESP barcode label here								
INDIVIDUAL SERIAL NUMBER: CHECK PERSON NO. Please write in below: YES NO Fasted sample	Checklist 1. Samples 2. Labels 3. Temperature indicator 4. Despatch								
Sample Taken: DAY: MONTH: YEAR: TIME	note								
Sample Taken: DAY: MONTH: YEAR: Date Posted:									
Please tick participant age group and which samples you are sending:									
PT AGED 18 mths – 6 yrs PT AGED 7-15 yrs	AGED 16+								
Colour Label Colou									
Lilac EN1 Lilac EN1 Lilac	EN1								

ONCE COMPLETED, PLACE INTO COOL BOX ON TOP OF THE POLYSTYRENE LID BEFORE SEALING THE BOX

Royal Blue SEN1

Royal Blue SEN2

LHN1

LHN2

EN2

Green

Green Purple

Royal Blue SEN1

Royal Blue SEN2

LHN1

Green

DESPATCH NOTE FOR ALL SAMPLES

DESP OFFICE

(OFFICE COPY)

1.	Participant details Please affix OFFDESP LABEL HERE (If providing blood sample)			INDIVIDUAL SERIAL NUMBER: CHECK PERSON No.					
2.	Age group:	16+ yrs	EDT/	A Seru		Li Hep LH	Serum TE		
		7-15 yrs	EDTA	A Ser	rum TE	Li Hep LH	Serum TE		
	18mth	ns – 6 yrs	EDTA	A Seru	um TE	Li Hep LH			
3.	Date blood sa	mple taken:			DAY:	MONTH:	YEAR:		
4.	Time blood sa	mple taken:				:			
5.	Date blood po	sted:			DAY:	MONTH	YEAR:		
6.	Time blood po	ested:			TIME	:			
7.	Royal Mail Tra	acking numbe	r:						
8. re	Did you expecord these belo					Venepuncture?			







National Diet and Nutrition Survey (NDNS) Nurse Visit

CHILD ASSENT FORM (5-15 years)

MR	EC Reference Number: 13/I	EE/0016		
Plea	se use capital letters and write i	n ink		Participant copy
SER	IAL NUMBER	CHECK LETTER	PERSON NO.	
1.	Have you been shown the 'Wi	hat hannens nevt leafle		Please circle
٠.	V5(05.02.2020) / V5.1 (01.12.		J.	Yes / No
2.	Has somebody explained wha	at happens at the nurse	e visit?	Yes / No
3.	Do you understand what this s	study is about?		Yes / No
4.	Have you asked all the question	ons you want?		Yes / No
5.	Have you had your questions	answered in a way yo	u understand?	Yes / No
6.	Do you understand it's OK to	stop taking part at any	time?	Yes / No
7.	Are you happy to take part?			Yes/No
	ny answers are 'No' or you don't ou do want to take part, you can	•		<u>)</u> !
You	er name			
The	nurse who explained this study	to you needs to sign t	00:	
Nur	se name ————			
Sig	nature			
Dat	e			

Thank you for helping us!







National Diet and Nutrition Survey (NDNS) Nurse Visit

CHILD ASSENT FORM (5-15 years)

MR	EC Refe	erence	Nun	nber	: 13/E	EE/00 ⁻	16			055
Plea	ase use ca	apital let	ters	and v	vrite i	n ink				Office copy
SEF	RIAL NUM	BER	1			CHE	CK LET	TER	PERSON NO	0.
1.	Have yo	ou been	shov	wn th	e 'Wh	at hap	pens ne	ext leaflet		Please circle
	V5(05.0	2.2020)	/ V5	5.1 (0	1.12.2	2021)'				Yes / No
2.	Has son	nebody	expl	ainec	d what	happe	ens at th	ne nurse v	/isit?	Yes / No
3.	Do you	underst	and v	what	this s	tudy is	about?			Yes / No
4.	Have yo	ou asked	d all t	the q	uestio	ns you	ı want?			Yes / No
5.	Have yo	ou had y	our o	quest	ions a	answer	ed in a	way you i	understand?	Yes / No
6.	Do you	underst	and i	it's O	K to s	top tak	king par	t at any tii	me?	Yes / No
7.	Are you	happy	to tal	ke pa	rt?					Yes/No
	<u>ny</u> answe ou do war			•					sign your na	ame!
Υοι	Your name									
Dat	e									
The	The nurse who explained this study to you needs to sign too:									
Nui	rse name									
Sig	nature									
Dat	e									

Thank you for helping us!







National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MREC Reference Number: 13/EE/0016									
Plea	se use capital letters and write ir	n ink		Participant copy					
SER	IAL NUMBER	CHECK LETTER	PERSON NO.						
				Please initial/					
Nam	e of Child			consent given					
1.	I am the parent/guardian of the read and understand the NDN 12.08.2020 (v7.1) / 01.12.202 the opportunity to ask question	IS Stage 2 information (v8) for the above	on sheet(s) dated study. I have been given						
2.	I understand that my child's pa withdraw from any part of the without my child's medical car	study, at any time, w	vithout giving a reason and						
Name	of Parent/Guardian (please print)	Date	Signature						
	of nurse (please print)	Date	Signature						
		and comple taken a	a mant of the aturdu						
3.	I agree to my child having a bl	·	•	. \square					
4.	I give permission that my child be stored and used in future re appropriate.	-							
5.	I would like to receive my child	d's blood results which	ch are clinically relevant.						
6.	I consent to my child's GP being clinically relevant.	ng notified of his/her	blood results which are						
7.	7. IF you do <u>not</u> want to receive your child's blood results <u>AND</u> if you do <u>not</u> want them sent to their GP, for us to take a blood sample from your child, you will be required to consent to both of the statements below.								
	(i) I confirm that against the advice of the NDNS survey team, I do not want to receive my child's blood results which are clinically relevant or have them sent to his/her GP.								
	(ii) I agree to the survey door results that are directly r		o discuss, if necessary, any s health.	′					
Name	of Parent/Guardian (please print)	Date	Signature						
Name	of nurse (please print)	 Date	Signature						







National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MR	EC Reference Number: 13/E	EE/0016								
Please use capital letters and write in ink										
SER	RIAL NUMBER	CHECK LETTER	PERSON NO.							
				Please initial/						
Name of Child										
1.	I am the parent/guardian of the child named above and I confirm that I have read and understand the NDNS Stage 2 information sheet(s) dated 12.08.2020 (v7.1) / 01.12.2021 (v8) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily.									
2.	I understand that my child's pa withdraw from any part of the without my child's medical car	study, at any time, w	vithout giving a reason and							
Name	of Parent/Guardian (please print)	Date	Signature							
Name	of nurse (please print)	Date	Signature							
BLC	OOD SAMPLE									
3.	I agree to my child having a bl	ood sample taken as	s part of the study.							
4.	I give permission that my child's blood sample taken as part of this study may be stored and used in future research studies with necessary approvals as appropriate.									
5.	I would like to receive my child	d's blood results which	ch are clinically relevant.							
6.	I consent to my child's GP bein clinically relevant.	ng notified of his/her	blood results which are							
7.										
	(i) I confirm that against the advice of the NDNS survey team, I do not want to receive my child's blood results which are clinically relevant or have them sent to his/her GP.									
	(ii) I agree to the survey doctor contacting me to discuss, if necessary, any results that are directly relevant to my child's health.									
Name	of Parent/Guardian (please print)	Date	Signature							
 Name	of nurse (please print)	Date	Signature							