NatCen Social Research

NISRA Northern Ireland Statistics and Research Agency

MRC Epidemiology Unit

UNIVERSITY OF CAMBRIDGE

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 not 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

I consent to my survey answers being linked to:

Hospital Episodes Statistics data	☐
Civil registration mortality data	☐
Cancer registration data	☐

I understand that information held and managed by NHS Digital may be used in order to provide information about my health status.

I understand that these details will be used for statistical and research purposes only.

Participant signature	Participant name	Date
Interviewer signature	Interviewer name	Date

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PARTICIPANT COPY
ADULTS 16+

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Hospital Episodes Statistics data	☐
Civil registration mortality data	☐
Cancer registration data	☐

I understand that information held and managed by NHS Digital may be used in order to provide information about my health status.

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Participant signature	Participant name	Date
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OFFICE COPY
ADULTS 16+

National Diet and Nutrition Survey (NDNS) Spot Urine Sample

STICK BARCODE LABEL HERE

ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER

CHECK LETTER

PERSON No.

SEX

MALE	
FEMALE	

SERIAL NUMBER

D	D	M	M	Y	Y

Please initial (or tick) boxes

1. I confirm that I have read and understand the NDNS Spot Urine Collection information sheet(s) dated 05.02.2020 (version 5)/ 01.12.2021 (version 5.1) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving a reason and without my medical care or legal rights being affected. ☐
3. I consent to provide a urine sample for the measurement of Iodine. ☐
4. I give permission for any remaining urine taken as part of this study to be stored and used in future research with necessary approvals as appropriate. ☐

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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PARTICIPANT COPY
ADULTS 16+

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ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER

CHECK LETTER

PERSON No.

SEX

MALE	
FEMALE	

SERIAL NUMBER

D	D	M	M	Y	Y

Please initial (or tick) boxes

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UNIVERSITY OF CAMBRIDGE

FOR POST OFFICE (COOL BOX) DELIVERY PROTOCOL

Please use capital letters and write in ink

INDIVIDUAL SERIAL NUMBER:
Please write in below:

								CHECK LETTER	PERSON NO.

ADDRESS

STICK **NCON** LABEL HERE (If providing blood 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)

Dr: ……

Practice Name: ……

Address: ……

……

Town: ……

County: ……

Postcode: ……

Telephone no: ……

NURSE USE ONLY

GP Address complete	1
GP Address not complete	2
No GP	3

8.

SUMMARY OF CONSENTS—RING CODE FOR EACH ITEM		**YES**	**NO**
a)	Read and understood the Stage 2 Information Sheet	01	02
b)	Understand right to withdraw	03	04
c)	Sample of blood to be taken	05	06
d)	Blood sample for storage	07	08
e)	Blood sample result to **participant**	09	10
f)	Blood sample result to **GP**	11	12
g)	**Does not** wish to receive results or have them sent to GP	13	14
h)	Agrees survey doctor can contact to discuss results if necessary –Children aged 1.5-15 years	15	16

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

NatCen Social Research

MRC Epidemiology Unit

UNIVERSITY OF CAMBRIDGE

National Diet and Nutrition Survey (NDNS) Nurse Visit

ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

Office copy

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

Please initial/tick boxes if consent given

1. 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 participation is voluntary and that I am free to withdraw from any part of the study, at any time, without giving a reason and without my medical care or legal rights being affected. ☐

Name of participant (please print) | Date | Signature

Name of nurse (please print) | Date | Signature

BLOOD SAMPLE

3. I agree to have a blood sample taken as part of the study. ☐

4. I give permission that my 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 blood results which are clinically relevant. ☐

6. I consent to my GP being notified of my blood results which are clinically relevant. ☐

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. ☐

Name of participant (please print) | Date | Signature

Name of nurse (please print) | Date | Signature

NatCen Social Research

MRC Epidemiology Unit | UNIVERSITY OF CAMBRIDGE

National Diet and Nutrition Survey (NDNS) Nurse Visit

ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

Participant copy

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

Please initial/tick boxes if consent given

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Name of participant (please print) | Date | Signature

Name of nurse (please print) | Date | Signature

BLOOD SAMPLE

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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. ☐

Name of participant (please print) | Date | Signature

Name of nurse (please print) | Date | Signature

NatCen Social Research

MRC Epidemiology Unit

UNIVERSITY OF CAMBRIDGE

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

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

Please initial/ tick boxes if consent given

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 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. ☐

Name of Parent/Guardian (please print) _____ Date _____ Signature _____

Name of nurse (please print) _____ Date _____ Signature _____

BLOOD SAMPLE

3. I agree to my child having a blood sample taken as 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's blood results which are clinically relevant. ☐

6. I consent to my child's GP being notified of his/her blood results which are clinically relevant. ☐

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 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 _____

NatCen Social Research

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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

Participant copy

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

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Name of Parent/Guardian (please print) _____ Date _____ Signature _____

Name of nurse (please print) _____ Date _____ Signature _____

BLOOD SAMPLE

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5. I would like to receive my child's blood results which are clinically relevant. ☐

6. I consent to my child's GP being notified of his/her blood results which are clinically relevant. ☐

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Name of Parent/Guardian (please print) _____ Date _____ Signature _____

Name of nurse (please print) _____ Date _____ Signature _____

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Blood sample Despatch Form

Please affix PCB DESP barcode label here

Nurse number:

INDIVIDUAL SERIAL NUMBER:
Please write in below :

CHECK LETTER

PERSON NO.

Fasted sample YES NO

Sample Taken: DAY: MONTH: YEAR:

Sample Taken: TIME

Date Posted: DAY: MONTH: YEAR:

Checklist

1. Samples
2. Labels
3. Temperature indicator
4. Despatch note

Please tick participant age group and which samples you are sending:

PT AGED 18 mths – 6 yrs

Colour	Label	
Lilac	EN1	
Royal Blue	SEN1	
Green	LHN1	

PT AGED 7-15 yrs

Colour	Label	
Lilac	EN1	
Royal Blue	SEN1	
Green	LHN1	
Royal Blue	SEN2	

PT AGED 16+

Colour	Label	
Lilac	EN1	
Royal Blue	SEN1	
Green	LHN1	
Royal Blue	SEN2	
Green	LHN2	
Purple	EN2	

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

DESPATCH NOTE FOR ALL SAMPLES **DESP OFFICE**

(OFFICE COPY)

1. Participant details

Please affix **OFFDESP** LABEL HERE (If providing blood sample)

INDIVIDUAL SERIAL NUMBER: Please write in below: | | | | | | | | | CHECK LETTER | PERSON. No.

2. Age group:

16+ yrs EDTA ☐ Serum TE ☐ Li Hep LH ☐ Serum TE ☐ Li Hep LH ☐ EDTA ☐

7-15 yrs EDTA ☐ Serum TE ☐ Li Hep LH ☐ Serum TE ☐

18mths – 6 yrs EDTA ☐ Serum TE ☐ Li Hep LH ☐

3. Date blood sample taken: DAY: | | MONTH: | | YEAR: | | | |

4. Time blood sample taken: TIME | | : | |

5. Date blood posted: DAY: | | MONTH | | YEAR: | | | |

6. Time blood posted: TIME | | : | |

7. Royal Mail Tracking number:

8. Did you experience any problems in taking the Venepuncture? If yes, please record these below and state what action you took. (PROMPTED FROM CAPI)

National Diet and Nutrition Survey (NDNS) Nurse Visit

CHILD ASSENT FORM (5-15 years)

MREC Reference Number: 13/EE/0016

Participant copy

Please use capital letters and write in ink

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

		Please circle
1.	Have you been shown the 'What happens next leaflet V5(05.02.2020) / V5.1 (01.12.2021)'	Yes / No
2.	Has somebody explained what happens at the nurse visit?	Yes / No
3.	Do you understand what this study is about?	Yes / No
4.	Have you asked all the questions you want?	Yes / No
5.	Have you had your questions answered in a way you 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

If any answers are 'No' or you don't want to take part, don't sign your name!

If you do want to take part, you can write your name below.

Your name _____

Date _____

The nurse who explained this study to you needs to sign too:

Nurse name _____

Signature _____

Date _____

Thank you for helping us!

NatCen Social Research

MRC Epidemiology Unit

UNIVERSITY OF CAMBRIDGE

National Diet and Nutrition Survey (NDNS) Nurse Visit

CHILD ASSENT FORM (5-15 years)

MREC Reference Number: 13/EE/0016

Office copy

Please use capital letters and write in ink

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

		Please circle
1.	Have you been shown the 'What happens next leaflet V5(05.02.2020) / V5.1 (01.12.2021)'	Yes / No
2.	Has somebody explained what happens at the nurse visit?	Yes / No
3.	Do you understand what this study is about?	Yes / No
4.	Have you asked all the questions you want?	Yes / No
5.	Have you had your questions answered in a way you 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

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If you do want to take part, you can write your name below.

Your name _____

Date _____

The nurse who explained this study to you needs to sign too:

Nurse name _____

Signature _____

Date _____

Thank you for helping us!

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National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

Participant copy

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

Name of Child _____

Please initial/ tick boxes if consent given

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2. 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 my child's medical care or legal rights being affected. ☐

Name of Parent/Guardian (please print) | Date | Signature

Name of nurse (please print) | Date | Signature

BLOOD SAMPLE

3. I agree to my child having a blood sample taken as part of the study. ☐

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6. I consent to my child's GP being notified of his/her blood results which are clinically relevant. ☐

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Name of Parent/Guardian (please print) | Date | Signature

Name of nurse (please print) | Date | Signature

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National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

Office copy

SERIAL NUMBER | **CHECK LETTER** | **PERSON NO.**

Name of Child _____

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Name of Parent/Guardian (please print) | Date | Signature

Name of nurse (please print) | Date | Signature

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Name of Parent/Guardian (please print) | Date | Signature

Name of nurse (please print) | Date | Signature