SAHMRI USE ONLY REDCap ID: **\_\_\_\_\_\_\_**

**PoppiE Study Patient Consent to Contact Form**

**GPs are working together with the South Australian Health and Medical Research Institute (SAHMRI) to inform women about the PoppiE Trial.**

The PoppiE trial is designed to determine the optimal level of iodine supplementation for pregnant women who already have an adequate iodine intake from the food that they eat.

You are being invited provide your contact details and give consent for a staff member from SAHMRI Women and Kids to contact you to discuss this research study further.

**By completing this form;**

* You agree to a member of the study team contacting you (prior to reaching 13 weeks of pregnancy) to discuss the PoppiE Study.
* You understand that your willingness to be contacted and to receive information about the PoppiE Study does not constitute your consent to participate.

**PATIENT CONTACT DETAILS**

**Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mobile: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

**PATIENT INFORMATION**

**Estimated Due Date:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ **OR Gestation:** \_\_ \_\_ weeks + \_\_ days

**Patient DOB:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ **Postcode:** \_\_ \_\_ \_\_ \_\_

**STAFF ONLY – GP INFORMATION**

**GP PRACTICE NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[ ]  Verbal consent obtained from patient

I [GP NAME] have explained the purpose of this ‘Consent to Contact Form’ to the above-mentioned patient.

**Signature of GP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

*Once completed, please send to* *lmarch@gppaustralia.org.au*