HEALTHCARE PROVIDER CONTACT FORM

*<insert study name>*

*<insert PI/Study contact information>*

**What is this form?**

In the *<insert plain language study title>* study there may be results about you that would be important for your healthcare provider or doctor to know.This form seeks permission to contact your healthcare provider or doctor if necessary. We also ask you for their contact information.

**When we would be required to contact your healthcare provider (where you don't have a choice):**

We must contact your healthcare provider if there is a result or medical finding that requires immediate attention, such as*<insert any plausible example from your type of study, e.g. A routine scan finding a tumor>.*

If you take part in this study, you agree that we can contact your healthcare provider when your study team decides it is necessary, generally for your safety and/or well-being.

Please know that medical care unrelated to the research will not be provided or paid for by the study, and you will need to follow up with your doctor.

**Reasons you can choose to let us contact your healthcare provider:**

<During and/or at the end of the study>, we will offer you some personal research results. If you like, we can also share these results directly with your healthcare provider so that they have them in the future. Examples include:

*<insert feasible reasons from study>*

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| --- |
| **Do you want us to share these optional results with your healthcare provider?**[ ]  Yes [ ] No [ ]  I don’t have a healthcare provider |
| Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please provide your healthcare provider’s name, address, and contact information.**If you don’t have a healthcare provider, please provide that last place you went for medical care.

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| Name of provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name & address of clinic, hospital, or office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Provider phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Clinic/hospital/office phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

**What if my healthcare provider changes?**

If you change healthcare providers, you can contact us at any time with their new information at:
<insert mode of contact>

We will also review this information at a later visit: <insert pre-specified review time if applicable>