**CONSENT TO CONTACT FOR RESEARCH PURPOSES**

**TITLE**: Transplant Wellness Program (TWP)

**SPONSOR:** University of Calgary

**FUNDER**: Private Donor

**INVESTIGATORS**:

Dr. Stefan Mustata, Principal Investigator, University of Calgary 403-943-8896

Dr. Kelly Burak, Co-investigator, University of Calgary 403-944-6555

Dr. Debra Isaac, Co-investigator, Foothills Medical Center 403-944-3262

Dr. Nicole Culos-Reed, Co-investigator, University of Calgary 403-220-7540

You are being invited to give consent for Dr. Stefan Mustata, or a qualified member of his study team, to contact you at some time in the future to invite you to participate in a research study.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to learn more about the Transplant Wellness study? (Circle one)

YES NO

If yes, you will be contacted at a later date. Please include your contact information below.

[ ]  **Phone:**  \_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **Email:**  \_\_\_\_\_\_\_\_\_\_\_\_

If No, can you please provide a reason?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You authorize your health service provider to share your name, telephone number and email address with the research team for the purpose of being contacted to learn more about the research study involving the Transplant Wellness Program.

Every effort will be made to safeguard your contact information. Although access to this information will be limited, there is a small chance that this information could be inadvertently disclosed or inappropriately accessed.

You have been made aware of the reasons why the contact information is needed and the risks and benefits of consenting or refusing to consent.

This consent is effective immediately. Your consent to be contacted can be revoked by you at any time.

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Services Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**