

Visualization of Asymptomatic Atherosclerotic Disease for Optimum Cardiovascular Prevention: VIPVIZA – a Population-based RCT nested in Routine Care in Sweden

NCT01849575

Informed consent, translation from Swedish to English



Informed consent

Personal id number.....

I hereby certify that I have received oral and written information concerning the trial, including the requirement for an ultrasound examination of the neck (carotid) arteries, and that I was invited to join the trial when I participated in the Västerbotten Intervention Programme.

YES I consent to participate in the study and I am aware that those participating in the study will randomly be allocated to informed or not informed about the results of the ultrasound examination. I am also aware that individuals who have severe stenosis of the carotid arteries will not be included in the study but will be offered a referral to the Stroke Center, Umeå University Hospital. I am also aware that among trial participants who have moderately pronounced changes in the neck arteries, a smaller group will receive more intensive treatment and / or closer ultrasound monitoring.

I am also aware that my participation is completely voluntary, and that at any time and without further explanation, I can withdraw my participation without prejudice to my future care within the healthcare system.

I consent to the authorized representative(s) of this study handling my personal data in accordance with the above information, including data in my medical records on cardiovascular risk factors, pharmacological prescription, and cardiovascular disease events for 10 years. I also consent to retrieval of information from the Pharmacological Registry at the National Board of Health and Welfare regarding purchase of prescribed pharmacological treatments aiming at prevention of cardiovascular diseases during the same period, as well as retrieval of data on revascularizing surgical procedures, myocardial infarctions and stroke events from local registers and from registers at the National Board of Health and Welfare.

I consent to this, provided there is full confidentiality during handling of the data.

Please sign below and also write your address, email and phone number so we can reach you, including during office hours

NO I do not consent to participate in this study Please sign below

Place..... Date...../.....20..... Signature.....

Printed name

Nurse: I have given oral and written information about the study to the above person:

Place..... Date...../.....20..... Signature.....

Health care center..... Printed name.....

If you answered YES: Contact information:

Address

Mail address

Phone number

Mobile number

I agree to get a reminder with SMS prior to the study visit