Alberta Children's Hospital
Permission to Contact for Research Purposes

At the Alberta Children's Hospital (ACH), we provide the highest quality of care to children and adolescents. Improving care includes finding new ways to diagnose, treat, and prevent illnesses. One way this is accomplished is through research conducted in association with the University of Calgary and Alberta Health Services (AHS). There are many research studies happening at ACH. Research personnel are responsible for appropriately selecting, enrolling, and providing follow-up throughout a research study.

WHAT IS PERMISSION TO CONTACT?
Permission to contact allows researchers to contact patients and families about studies for which they may be eligible. We would like to ask for your permission for AHS and/or University of Calgary research personnel to review your child's electronic chart to determine if they meet the requirements to participate in research studies.

WHAT HAPPENS IF WE SIGN THIS FORM?
By signing this form, you are providing permission to be contacted about potential research opportunities. Your child's medical record will indicate that you have given this permission. Your child's information will be included on a list within the electronic medical record system for a specific department/condition. This list will not be shared with other departments/groups. However, other departments may have their own lists. If you visit other areas of the hospital, you may be asked about other lists as well. These lists are confidential; only research teams or those involved in clinical care have access.

Signing this form does not mean your child will be entered in a study. If you give permission to be contacted and a researcher thinks your child meets the criteria for a study, someone from the research team will contact you to provide detailed information about the study. At that time, you and your child can decide if you want to participate. If you and your child decide not to participate in the research study, you may still be contacted about other studies. Multiple research teams within a department may have access to the list of patients who have given permission to be contacted.

WHAT HAPPENS IF WE DO NOT SIGN THIS FORM?
Declining will have no influence on your child's present or future status as a patient in this hospital. Your child will receive the same care as any other patient seen in the hospital. There will be no penalty or loss of benefits to which you are otherwise entitled.

If you visit other areas of the hospital, you may be asked by other departments/groups if you wish to give permission to be contacted for lists specific to that department/condition.

SCREENING ACTIVITIES
The following information may be reviewed/collected for screening purposes:

- Child's name
- Age
- Gender
- Alberta Personal Health Number (PHN)
- Primary care provider name
- Contact information (phone number, address, email)
- Reason for hospital visit/diagnosis

RISKS
There are minimal risks associated with providing permission to be contacted. Access to the information provided as part of this process will be limited, but there is a small chance that this information could be inadvertently disclosed or inappropriately accessed. Every effort will be made to safeguard your personal information.

CAN I CHANGE MY MIND?
Yes. You can be removed from the list at any time. Please ask a researcher or member of your clinical care team if you wish to be removed from the list. Removal is list specific, so you must contact each department/group individually if you have agreed to participate in other lists/departments.

CONTACTS
If you have any questions about this process please contact:
INCLUDE CONTACT INFORMATION FOR PTC LIST MANAGER FOR UNIT

PERMISSION TO CONTACT
I understand that I am being asked to voluntarily provide access to my/my child's electronic chart to be included in a list for research screening purposes. I may withdraw this permission at any time by contacting a member of the research team, or the clinical care team. My/my child's medical care will not be affected by this decision now or in the future.

Patient's name _____

_____ _____
Patients' signature Date

Parent/guardian name_____

_____ _____
Parent/guardian signature Date

Preferred contact method:

☐ Telephone: *Please provide your preferred contact number*_____

☐ Email: *Please provide your email address*_____

☐ Video conference (e.g. Zoom meeting) *Please indicate if you prefer to be contacted by phone or email to set up a video call.*