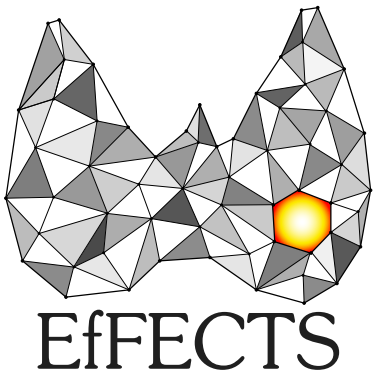

INFORMED CONSENT FORM

For participation to the clinical research trial:

Efficacy of FDG-PET/CT in Evaluation of Cytological indeterminate Thyroid nodules prior to Surgery (EfFECTS)

I declare that I have been informed about the study and its nature, goals, methods, risks and burden, in a way that I could understand and to my satisfaction. I know that one of the investigators, involved with this research project, may access my medical files. I know that qualified persons, as mentioned in the patient information letter, may access my medical files. I know that data and results of this investigation are only presented to third parties in an anonymous and confidential fashion. I have read all provided patient information carefully. I had sufficient opportunity to ask questions about the study. My questions were answered to my satisfaction. I was able to take the time to consider study participation. I give my voluntary consent to participate in this study. I reserve the right to withdraw my consent at any time, and end my study participation without having to provide argumentation for my decision.
If I don't want that my family doctor be notified of my study participation, I have explicitly notified the investigators of this. I know that the research data that concern me will be stored for 15 years. I give consent to additional analysis of my thyroid tissue in the Radboudumc, as mentioned in the patient information letter. I give consent for forwarding a copy of this informed consent form to the investigators in the Radboudumc.

[to be filled by patient himself/herself]

Last name + initials : .....

Date of birth : ☐☐-☐☐-☐☐☐☐

Inform family doctor: ☐ **I approve** ☐ **I do not approve**

signature : **date :** ☐☐-☐☐-☐☐☐☐

Undersigned declares that the person mentioned above has been informed about the study mentioned above, both in writing as verbally. He/she declares that premature withdrawal from the study by the person mentioned above, will not affect the care that he/she deserved in any way.

[to be filled by investigator]

Last name + initials : .....

profession : .....

signature : **date:** ☐☐-☐☐-☐☐☐☐

Send a copy of the fully filled informed consent form to: Lisanne.deKoster@radboudumc.nl
Or by mail to: LUMC, afd. Nucleaire Geneeskunde C2-P, t.a.v. L. de Koster, postbus 9600, 2300RC Leiden.
Save the original form in the patient medical file or investigator site file. Give a copy to the patient.

Claim form for travel expenses concerning participation in the EfFECTS study

When you travel to your hospital specifically for the PET/CT scan or the follow-up ultrasound after 12 months, you receive a compensation of €0,19 per kilometer for your travel expenses (return trip). The medical ethical research committee has approved this compensation. The distance of your return trip is calculated using a common route planner. The calculated compensation is transferred to your bank account.
Note: only a fully completed form can be considered for compensation.

To be filled by patient:

Address + number:	
Zip code + place:	
Hospital:	☐ AMC ☐ St. Antonius ☐ Erasmus MC ☐ Hagaziekenhuis ☐ Isala ☐ Meander MC ☐ LUMC ☐ MUMC ☐ OLVG ☐ Radboudumc ☐ Reinier de Graaf ☐ Rijnstate ☐ UMCG ☐ UMCU □ VUmc □ other: ……
Reason for hospital visit:	☐ ^{18}F-FDG-PET/CT □ follow-up ultrasound of the neck (after 12 months)
Bank account number (IBAN):	
In the name of:	
Citizen Service Number Burgerservicenummer (BSN):	

Signature to declare that the above has been filled truthfully:	
Date (DD-MM-YYYY):	– –

To be filled by investigator:

Aantal kilometers enkele reis woonadres naar ziekenhuis gebaseerd op GoogleMaps ____ km, dit is retour: ____ km

Vergoeding (à € 0.19/km) € ____ . ____ Paraaf: ____

Return the completed form to the investigators, preferably by email: Lisanne.deKoster@radboudumc.nl
Or by mail: LUMC, afd. Nucleaire Geneeskunde C2-P, t.a.v. L. de Koster, postbus 9600, 2300RC Leiden.