

**ERACODA**

 The ERA-EDTA COVID-19 Database

**Informed consent form for the ERACODA registry**

**Use of medical data**

In the [*name hospital*] we join the ERACODA patient registry to obtain more knowledge about the disease caused by the new Corona virus (COVID-19) in kidney patients. The goal of this registry is to improve the care and prognosis of patients with COVID-19 and kidney disease. To do this, we use your medical data. While doing so we will adhere to the legislative framework regarding privacy.

**Medical data**

Medical data consist of data which is generated during examinations, diagnostic tests and medical treatments. These data are collected in your health record. Examples of medical data are, name of an illness (diagnosis), results from blood tests, medication that is used, treatment and results of this treatment, results of imaging (X-ray / CT / MRI)

**Privacy**

Your medical data are confidential and part of the patient-doctor confidentiality. Before we can use your medical data for scientific research, we will replace personal data that could be used to identify you by a code. Without the key to this code, it will not be possible to trace the medical information back to you. The key to this code is kept by the local investigator and not accessible for other investigators. Only the local investigator has access to the key in case additional data need to be collected and/or to check the quality of data that have already been collected. If your medical information is also collected in other registries, with this code we can request additional medical information to make the medical information in the present ERACODA registry as complete as possible. We will keep your data confidential and adhere to the laws governing privacy all the time. A note will be added to your patient file that states that you have given consent.

**Results of the scientific research**

You will not personally receive the results of the scientific research for which your medical data are being used. For information regarding new findings to be obtained via this project, for instance regarding new treatment strategies, we kindly refer you to your treating physician.

**Informed consent**

We can only use your (or your relatives) medical information for this patient registry if you give written consent. Therefore, we ask for your consent in this letter. If you decide to give consent, you can withdraw your consent any time. To do this, reach [name] by [phone] or [mail]. In case you decide to withdraw your consent, the medical information will be deleted from the registry for future use. We will make a note of your consent in your patient file.

**Informed consent form for the ERACODA patient registry to investigate COVID-19 in kidney patients**

- I have read this information letter and had the opportunity to ask questions. My questions have been answered sufficiently.

* I know that participation in this patient registry is voluntary. I know that I can withdraw my consent at any time. If I decide to withdraw my consent, my medical information that is collected will be destroyed. However, if my medical information was already used for studies, this information cannot be deleted.
* I give consent to request medical information collected in other hospitals and by other physicians. If my medical information is also used in other registries about kidney disease, data from these registries may also be requested to complete my medical information needed for the present research project.
* I know that my medical information will be stored for 15 years, to be able to check information afterwards. I know that my medical information may be used for follow-up studies to investigate the long-term consequences of COVID-19.
* I □ **do**

□ **do not**

 give consent to approach me for further follow-up studies.

***Sign at next page →***

**Personal information**

*I would like to join the ERACODA patient registry and hereby give my written consent that my medical information can be used for this registry.*

Name, initials: ………………………………………………………………………………………

Date of birth: ………………………………………………………………………………………

Place: ………………………………………………………………………………………

Date: ………………………………………………………………………………………

Signature: ………………………………………………………………………………………
*If you fill in this form as a relative, leave this field blank and fill in the information below*

**If you fill in this form as a relative, note your personal information here:**

Name, initials: ………………………………………………………………………………………..

Relation to patient: ………………………………………………………………………………………

Place: ………………………………………………………………………………………

Date: ………………………………………………………………………………………

Signature ………………………………………………………………………………………

**To fill in by the local investigator (or his/her representative)**

Name, initials: ………………………………………………………………………………………

Place: ………………………………………………………………………………………

Date: ………………………………………………………………………………………

Signature: ………………………………………………………………………………………

*The patient or relative will receive the information letter and a copy of this signed informed consent form.*