

# Community Pharmacies Mood Intervention Study (CHEMIST)

## PART 1: CONSENT FORM

If you wish to take part in the CHEMIST study, **please place your INITIALS in each of the boxes below, print your name, sign and date this form. Please also complete the questions in Part 3 (Essential Background Information).** The consent form in Part 2 is optional. **Please return these forms in the pre-paid envelope provided.**

Please do not hesitate to contact Liz Littlewood, the study co-ordinator, on 01904 321828 if you have any questions about the study. **The information on this form will be kept confidential and won't be released to anyone outside the research team.**

*Please INITIAL  
each box*

1. I confirm that I have read and understand the information sheet version 2.1 dated 06/02/2018 for the above study, which explains what the study is about and how my information will be used. I have had the opportunity to ask questions by phoning the contact number provided.

INITIALS

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my medical care or legal rights being affected. I understand that I need to let the study team know if I wish to withdraw from the study.

INITIALS

3. I understand that sections of my health care records may be looked at by researchers from the CHEMIST Study, and that information held by the NHS Information Centre and the NHS Central Register may be used to keep in touch with me and follow up my health status for the duration of the study.

INITIALS

4. I understand that information, including my date of birth and postcode, may be shared with the NHS Information Centre, specifically for service auditing purposes. I give permission for these individuals to have access to my records.

INITIALS

5. I agree to my GP being informed of my participation in the study and of any health concerns the CHEMIST study team may become aware of during my participation.

INITIALS

6. I agree to take part in the CHEMIST study.

INITIALS

\_\_\_\_\_  
**PARTICIPANT'S NAME**  
*(PLEASE PRINT IN BLOCK CAPITALS)*

\_\_\_\_\_  
**TODAY'S DATE**

\_\_\_\_\_  
**PARTICIPANT'S SIGNATURE**

## PART 2: OPTIONAL CONSENT FORM

This part of the study is optional. You can decide if you wish to take part or not and it will not affect your participation in the study. Please ONLY INITIAL the boxes you wish to consent to.

***Please only INITIAL  
boxes that apply***

1. I am willing to have some of my sessions with the health worker audio recorded and reviewed by experts in the UK for research purposes only.

INITIALS

2. I am willing to be interviewed about my experiences of taking part in the study and for this interview to be audio recorded for research purposes only.

INITIALS

3. I agree to the data collected as detailed in statements 1 and 2 above being retained for 10 years, even if I decide to withdraw from the study and that it will only be used for this study.

INITIALS

4. I agree to my data from this study being shared with other health researchers after my personal identifying information has been removed. I understand that it will only be used towards improving health outcomes by assessing the types of treatment that I have agreed to participate in for the main study.

INITIALS

5. I am happy to receive a thank you payment of £5 for each of the two times I complete the study questionnaires.

INITIALS

6. I am happy to receive information about other related future studies.

INITIALS

\_\_\_\_\_  
**PARTICIPANT'S NAME**  
**(PLEASE PRINT IN BLOCK CAPITALS)**

\_\_\_\_\_  
**TODAY'S DATE**

\_\_\_\_\_  
**PARTICIPANT'S SIGNATURE**

## PART 3: ESSENTIAL BACKGROUND INFORMATION

The following information is required for the study:

**Title:**..... **Name**..... **Date of Birth**.....  
(BLOCK CAPITALS)

**Address**.....

.....**Postcode**.....

**Telephone contact details:**

**OK to leave messages on this phone?**

**Day**.....  **Yes**  **No**

**Evening**.....  **Yes**  **No**

**Mobile**.....  **Yes**  **No**

**Email address (optional)**.....

**Name of your GP**.....

**Name of your GP Practice**.....

**GP Practice Address**.....

**GP Practice Postcode**..... **Phone Number**.....

**NHS number (if you know it)**.....

**How were you recruited i.e. how did you find out about the study?** *(Please choose 1 option)*

1. Pharmacy  **Which Pharmacy?** .....

2. I saw a poster advertising the study

3. I saw the study advertised on the internet

4. My GP practice sent me information

## PART 3: ESSENTIAL BACKGROUND INFORMATION CONT'D

Please answer the following questions about yourself:

1. What is your date of birth?   /   /      
Day Month Year
2. Are you? Male  Female
- 3 a) During the last month, have you often been bothered by feeling down, depressed or hopeless? Yes  No
- b) During the past month, have you often been bothered by having little interest or pleasure in doing things? Yes  No
4. Which of the following best describes your current situation with regard to smoking? (Please cross one box only)  
I have never smoked  I currently smoke  I am an ex-smoker
5. On average, do you drink 3 or more units of alcohol each day? (1½ pints of beer or 3 glasses of wine or 3 short measures of spirits) Yes  No  Don't know
6. Do you experience any of the following health problems? (please cross all that apply)  
Arthritis  Cancer  Diabetes  Stroke   
Cardiovascular Conditions (e.g. heart attack, heart failure, angina, high blood pressure)   
Respiratory Conditions (e.g. COPD, asthma, bronchitis)   
Progressive Conditions (e.g. motor neurone disease, Parkinson's Disease, multiple sclerosis)   
Other  Please state: .....
7. Did your education continue after the minimum school leaving age? Yes  No
8. Do you have a degree or equivalent professional qualification? Yes  No
9. To which of these ethnic groups do you consider you belong? (Please cross one box only)  
White  Asian or Asian British  Black or Black British   
Other ethnic group   
Please describe: \_\_\_\_\_
10. Number of children 0  1  2  3  4+
11. Marital Status (please cross one box only)  
Single  Divorced/separated  Widowed   
Cohabiting  Civil Partnership  Married

**Thank you for completing these forms!**  
**Please return all 3 parts of this form in the enclosed pre-paid envelope.**