



CONSENT FORM

THIS FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Project title: Unveiling Meibomian Gland Dysfunction Impact and Risk Factors
Researchers: Professor Jennifer P. Craig, Dr Phil Turnbull, Dr Kalika Bandamwar, Dr Ally Xue,
Mr Jordan Cooper, Ms Catherine Jennings

I have read and understood the details of the study described in the Participant Information Sheet, including the nature of the research, why I have been selected, and the time required of me. I confirm that I am providing my consent prior to any study-related activities being conducted.

- I agree to take part in this research study to explore the prevalence, risk factors and impact of meibomian gland dysfunction (MGD). I understand that the time required for the single clinic visit will be up to 1 hour.
- I have had the opportunity to discuss this study, to use a whānau support or friend as appropriate, and am satisfied with the answers I have been given.
- I understand that taking part in this study is my decision, that I may withdraw from the study at any time and withdraw my data from the study up to two weeks after my clinic visit.
- I understand that clinical data will be kept for six years in locked filing cabinets, after which time they will be safely destroyed.
- De-identified electronic data will be stored for at least 10 years on a password protected University of Auckland Research Drive, and when no longer required will be securely destroyed.
- I understand that the study results might be submitted for scientific publication or presentation at conferences but that I will not be individually identifiable in any report.
- I understand that my deidentified data may be combined with other datasets collected by the research team to further understand this condition and improve health outcomes for patients in the future. Request for future use of my data would require further ethical approval to be sought and obtained.
- If I am a student at, or a patient of, the University of Auckland, I understand that participation or non-participation will in no way influence my academic progress or clinical care, respectively, and I know who to contact should I feel this has been breached in any way.
- I understand that my participation in this study is confidential and that no material, which could identify me, will be used in any reports on this study
- I know whom I can contact if I have any further questions about the study.
- I am happy for the researchers to inform me of any incidental finding(s) detected during examination, and to arrange for management of the finding or to directly refer me to my general practitioner and/or relevant healthcare provider, as appropriate.
- I would like to receive a summary of the research findings: YES / NO

If so, please include an email address: _____

I hereby consent to take part in this study:

Signed: _____

Date: ___/___/___

Project explained by:
Project role:

Signature:
Date: