UNIVERSITY OF CALIFORNIA SAN FRANCISCO (UCSF)
CONSENT TO BE CONTACTED FOR FUTURE RESEARCH

Autism & Neurodevelopment Program

Departments of Psychiatry, Neurology, Radiology & Genetics
and Langley Porter Psychiatric Institute

What is the purpose of this consent? The doctors in the Autism Clinic at UCSF are doing research that is designed to lead to better treatments for autism spectrum disorders (ASDs) and neurodevelopmental disorders (NDDs). They want to know if you wish to learn more about their research studies or if you and your child may wish to participate in any of the studies that may be appropriate for you. By signing this form, you will be allowing qualified professional people from the Autism and Neurodevelopment Program to contact you in the future to ask if you and your child want to participate in any studies. You have no obligation to actually participate in any studies.

What happens if I sign this form? If you sign this form, you are giving consent for the information that you will be filling out on this form to be put into a database. This includes information about your child's diagnosis, name, date of birth, and contact information. This information will be kept indefinitely, unless you withdraw your permission. If a study that includes individuals with your child's diagnosis needs subjects, you may be contacted to ask if you and your child want to participate. You do not have to participate. You may withdraw permission to be contacted at any time by contacting the clinic.

What happens if I don't sign this form? Declining to participate will have no influence on your child's present or future status as a patient in this clinic. Your child will receive the same quality of care as any other patient seen in this clinic. There will be no penalty or loss of benefits to which you and your child are otherwise entitled. Your clinic records will indicate that you do not want to be asked about future research by or through anyone but your treating physician.

Are there any risks to my signing this form? Participation in research may involve some loss of privacy. However, your child's records will be handled as confidentially as possible. Access will be limited to the data manager and the doctor organizing the study and will require a password.
No information will be used for research without additional permission. Your contact information will not be shared with anyone outside of this clinic.

Are there any financial considerations? There will be no cost or payment if you sign this form.

What do I do if I have questions, now or later? You can talk with the study researcher about any questions, concerns or complaints you have about this study. You may contact the study researcher(s) Dr. Elysa Marco at 415-353-2567, Dr. Bryna Siegel at 415-476-7321, or Dr. Robert Hendren at 415-476-7198.

If you wish to ask questions about the study or your rights as a research participant to someone other than the researchers or if you wish to voice any problems or concerns you may have about the study, please call the Office of the Committee on Human Research at 415-476-1814.

What do I do to consent? If you agree to be contacted in the future, please fill out the information below, indicate your preferred contact method and sign below.
If you participate in research, you will be asked to sign a separate HIPAA Authorization Form authorizing access, use, creation, or disclosure of health information about you.

Participant:

Name (print): _____ _____ _____
First *Middle* *Last*
Date of Birth: ___/___/___ Female___ Male___
Town/Municipality of Birth: _____
Ethnicity:_____
Handedness: R___ L___ Ambidextrous _____

Mother:

Name (print): _____ _____
First *Last*
Date of Birth: ___/___/___ Ethnicity: _____

Father:

Name (print): _____ _____
First *Last*
Date of Birth: ___/___/___ Ethnicity: _____

Contact Information:

Home Address:
Street: _____
City: _____
State: _____ Zip: _____
Phone: Home: _____
Work: _____
Cell: _____

Best time to Call: *(please circle)*
Morning / Afternoon / Evening
Weekday / Weekend

E-mail:_____

Preferred contact method:
Phone / Mail / Email (*please circle*)

If you wish to be contacted about future research, please sign below.

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Participant is a minor:

The person being considered for this study is unable to consent for himself/herself because he/she is a minor. By signing below, you are giving your permission for your child to be included in this study.

Parent/Legal Guardian name (print):_____

Signature:_____ Date: _____

Participant is an adult:

Participant's name (print):_____

Signature:_____ Date: _____

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For clinic use only:
Person Obtaining Consent (print): _____ Signature:_____ Date: _____

Axis 1: ☐ *None* ☐ *Aut* ☐ *PDD* ☐ *Asp* ☐ *Lang* ☐ *ADHD* ☐ *Other:*_____ ☐ *R/O*

Axis 2: ☐ *No MR* ☐ *Border* ☐ *Mild* ☐ *Moderate* ☐ *Severe* ☐ *N/A* ☐ *Unspec.* ☐ *R/O*

Testing: ☐ *ADOS* ☐ *ADI-R* ☐ *Other:* _____

Criteria: ☐ *DSM-IV-TR* ☐ *DSM-V*

Clinician:_____ ***Clinic:***_____ ***Date:*** _____