INFORMED CONSENT TEMPLATE
CONSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY

Study Title:	**A Randomized Controlled Clinical Trial of Clarification of Optimal Anticoagulation Through Genetics**
Study Key Name:	**COAG Study**
Principal Investigator:	**[Insert Name, Address, and Phone Number of the Principal Investigator]**
Emergency Contact:	**[Insert Emergency Contact Insert Phone Number/Pager, etc]**

Introduction

We invite you to take part in a clinical research study called Clarification of Optimal Anticoagulation through Genetics (COAG) at the (NAME OF INSTITUTION). This form is called a consent form. The purpose of this consent form is to give you information to help you decide if you want to be in this study. Please read this form carefully before deciding whether you want to take part. This information will also be discussed with you by the research team. If there is anything you do not understand about this study, please ask the study doctor and/or research team any questions you have before you make your decision. If you decide to take part in this study, you will be asked to sign this form and you will be given a signed copy of this form.

Being in this research study is voluntary. You do not have to take part in this study if you do not want to. If you do take part in this study, you can leave the study at any time, and for any reason. You do not have to participate in this research study in order to receive treatment.

This study is sponsored by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH). This study will be conducted at about 18 clinical centers throughout the United States of America. It will include a total of about 1,022 participants and the study will end in July 2013.

Why you are being asked to take part in this research study?

You are invited to take part in this study because your doctor recommends that you begin taking the medication warfarin for at least one month. Warfarin is also known by the "trade name" *Coumadin*® and is in a class of medications called anticoagulants or "blood thinners." Warfarin works by reducing the clotting ability of the blood. It is used to stop blood clots from forming or growing larger in your blood and blood vessels.

Warfarin is prescribed for many conditions, including for people with certain types of irregular heartbeat, people with replacement or mechanical heart valves, people who have suffered a heart attack, people who have had orthopedic surgery, or who have a history of having blood clots. Warfarin is used to prevent or treat deep vein thrombosis (swelling and blood clot in a vein), pulmonary embolism (a blood clot in the lung), and strokes (a blood clot in the brain).

What is the purpose of this research study?

The purpose of this research study is to find out the best way to start warfarin treatment.

Individuals vary in the dose of warfarin they need to have safe and effective levels of blood thinning. Individuals can vary in how their bodies use (break down) and react to warfarin. Therefore, you may need a different dose of warfarin than another person. Some of these differences are due to differences in age, race, sex, weight, and medical conditions.

Along with these differences, the use of genetic information may also help doctors find the dose of warfarin that you need. Genes are like a set of instructions that tell your body's cells what to do. Genes carry the messages that tell cells when and how to make certain chemicals necessary for the growth and health of the body. Researchers have found that certain genes may affect how a person's body will break down or react to warfarin. If genetic information can help doctors better determine the best dose of warfarin before it is first given, this may help the doctors to get you to the correct levels of blood thinning and thereby reduce the risk of bleeding or the risk of developing a blood clot. This study will test whether doctors can improve the control of blood thinning by using genetic information. This genetic testing is done by a blood test that will be conducted on everyone in this study.

There are likely to be many genetic differences (also called "variations") that contribute to a person's response to warfarin, but not all of them have been discovered yet. Recent scientific advances allow researchers the ability to search for all possible genetic changes that might be related to warfarin response. These are often called "genome-wide association studies" or "sequencing studies." These

studies will also be conducted on everyone in the COAG study to determine even better ways of giving warfarin treatment in the future.

Throughout your treatment with warfarin, you will have regular blood tests, called INR (International Normalized Ratio), to check how the warfarin in your blood is working. This test is done frequently as part of regular medical care for all patients on warfarin in order to help your doctor provide you with the dose of warfarin that it is right for you. It is sometimes necessary to change the dose of warfarin to avoid too much thinning of the blood which can lead to serious bleeding, or too little thinning of the blood which can allow clots to form in the blood vessels. Frequent INR blood tests will be done on everyone in this study. This is common in patients using warfarin and would be done whether or not you decide to participate in the study.

Several things such as food, alcohol, other medications, or medical conditions, can change how your body breaks down or responds to warfarin. This can change your INR and the dose of warfarin that you need. This study will also look at how these factors (such as other medications) can affect warfarin therapy and how genetics might change your response to these other factors.

How long will I be in this research study?

Your participation in research study visits will be for six (6) months. All study visits will end in July 2013. If you are enrolled in the study after February 2013, your participation will end in July 2013, and your study visits will be for less than six months. Future studies that use information from this research study will continue after your participation in the research study ends.

How many people will take part in this study?

The total number of people in the study will be about 1,022, from 18 medical centers in the United States. Approximately (*xxx number)* people will be enrolled in this study at the [name of institution].

What is involved in this research study?

If you agree to be in this research study, information will be collected to see if you are eligible for the study. This is called a screening visit which will occur before you receive your warfarin treatment in the hospital or at your first out-patient visit to the anticoagulation clinic.

Screening Visit

At your screening visit you will be interviewed by the research coordinator and asked questions about your medical health and health habits related to smoking and alcohol use. You will be asked to answer questions about your medical

condition, medical history, food and diet information, the quality of your life, and medications you are taking.

A blood sample (approximately 3 teaspoons) will be taken from you. The laboratory at [INSTITUTION NAME] will use part of this sample to determine the genetic differences (variations) that may be used in the study to help determine your warfarin dose. The rest of this blood sample will be sent to a central laboratory. This laboratory will perform quality checks on the results from the laboratory at [INSTITUTION NAME]. The rest of your samples will be stored and used to study genes and other factors in the blood that may affect how people respond to warfarin.

Study Participation

If the research doctor determines that you are eligible to participate in this study, you will be randomly assigned by chance (like flipping a coin) to one of two treatment groups. One group will receive their warfarin dose based on a formula that uses clinical information only (such as age and weight) to calculate a person's warfarin dose. This is called the "clinical-guided arm" of the study. The other group will receive warfarin based on a formula that uses clinical and genetic information to calculate a person's warfarin dose. This is called the "genotype-guided arm" of the study.

The treatment assignment to either the clinical-guided group or the genotype-guided group is a blinded assignment. This means that the study doctor, the study staff, and you will not know which treatment group you are in. The reason for a blinded assignment is to make sure that the study meets strict scientific standards and that the results are therefore accurate. For the first 4 weeks you are in the study, the dose of warfarin you get will not be known to the study doctor, the study staff, or to you. However, this information is available to your study doctor in case of an emergency.

Taking the Study Medication

After you are enrolled in the study you will receive a daily dose of the warfarin study medication based on the study group that you are in. You will not know the dose of the warfarin. After you receive the first few doses, your dose will again be changed based on formulas designed for your study group. After this, the frequency of INR blood tests and dose of your warfarin will be adjusted using a standard method of medical care for warfarin therapy. You will be given instructions about how and when to take the study medication. If at any time your health care provider feels that your dose should not be determined by the study methods, your dose can be changed.

Clinic Visits While Taking the Study Medication

You will be scheduled for your clinic visits for the first month. While receiving warfarin medication, you will be asked to return to the clinic for all scheduled visits so that the safety and effectiveness of the study treatment can be checked.

These visits are part of the regular care that all patients on warfarin get. During the first and second week, you will come to the clinic twice each week. During the third and fourth week, you will come to the clinic once each week. In addition to the clinic visits, a phone call between you and the research coordinator may be needed to find out how you are adjusting to the study medication and to report any medication side effects you may be experiencing. After the fourth week, you will come to the clinic once a month for the rest of the study (up to month 6). During these visits, you will also be asked to complete questionnaires to assess your quality of life, preferences and use of inpatient and outpatient medical services. Depending on your INR results, you may need to come to the clinic more frequently. Your final study visit will be at month six (6),or for a shorter period if you are enrolled after February 2013.

Clinic Visits When Not Taking Study Medication

Should you or the study doctor decide to stop your warfarin medication before the final study visit at month six, you will be asked to continue your participation in the study even if you are not taking study medication. Your continued participation in the study will involve your completing study questionnaires and providing follow-up information until the final study visit at month six (6).

What are the risks of taking part in this research study?

There are risks in taking warfarin and there are risks from being in a research study. These are described below. Also, there may be risks or side effects we do not know about yet.

Warfarin Risks *(*These are risks that can occur to all patients on warfarin, whether they are in this study or not)

Side effects of warfarin therapy: Most side effects relate to how warfarin works. To minimize the risk of bleeding, health care providers try to keep your blood thinning in the correct range. However, even when your blood thinning is in the proper range, you might have side effects. Some people may experience hair loss or skin rashes, but this is rare. If you notice something wrong that you feel may be caused by your medication, call your doctor.

Common Side Effects: Warfarin can cause slight bleeding—you may notice gum bleeding while brushing your teeth, an occasional nosebleed, easy bruising, bleeding after a minor cut that stops within a few minutes, or menstrual bleeding that is a little heavier than usual.

Serious Side Effects: Warfarin can cause serious and even life-threatening bleeding problems. The following are signs of more serious bleeding that mean you should contact your doctor or go to the hospital emergency room: red, dark, coffee or cola colored urine; bowel movements that are red or look like tar;

bleeding from the gums or nose that does not stop quickly; vomit that is coffee colored or bright red; anything red in color that you cough up; severe pain, such as a headache or stomach ache; sudden appearance of bruises for no reason; menstrual bleeding that is much heavier than normal; a cut that will not stop bleeding within 10 minutes; dizziness or weakness.

Use of Other Medications: When warfarin is taken with other medicines it can change the way the warfarin work. It can also change the way those other medicines work. It is important to talk with your health care provider and study staff about all of the other medicines that you are taking, including prescription medicines, over-the-counter medicines, antibiotics, vitamins, or herbal products. You also should talk with your health care provider before starting any new medicines or stopping any of your current medicines.

Diet and Alcohol: The foods you eat can affect how well warfarin works for you. Before starting a weight loss plan while taking warfarin, you should first discuss it with your doctor. Alcohol can affect your warfarin dosage but it does not mean you must avoid all alcohol. Serious problems can occur with alcohol and warfarin when you drink more than two (2) drinks a day or when you change your usual diet or alcohol consumption.

Pregnancy Risks: Because warfarin might be harmful to a pregnant woman and/or the unborn child, women of childbearing potential must have a negative pregnancy test at the time of screening if they wish to participate in this trial. Women of childbearing potential also must agree to use a reliable form of contraception (birth control) during this study. Please note that the rhythm method is not a medically accepted form of birth control.

Medically acceptable birth control methods for this study include:

- hormonal methods (birth control pills, or injected or implanted contraceptive),
- intrauterine device (IUD) with spermicide,
- condom with spermicide or
- diaphragm with spermicide.

Even if you use a medically acceptable birth control method, you could still become pregnant. If you suspect that you are pregnant, it is important to the safety of your unborn child that you tell your health care provider immediately. They will determine if warfarin should be stopped. If you must continue on anticoagulation therapy, it will be supervised by the doctor/health care provider you have chosen to care for you during your pregnancy. You must also notify the study doctor/staff immediately.

Research Risks (These are risks that can occur from participating in this study.)

Risks associated with drawing blood: Some possible risks and discomforts you could experience during this study include physical discomfort such as a sharp sting from the needle used to collect blood from your arm. There is a small chance that you will develop a bruise or an infection at the needle site, or you may feel lightheaded or faint.

Risks of the Study Dosing: The goal of the study is to try to keep your blood thinning in the correct range. If the use of one of the study dosing methods leads to a higher amount of blood thinning than desired, this may increase your risk of side effects from warfarin (as detailed in the "**Warfarin Risks**" section above). If the use of one of the study dosing methods leads to a lower amount of blood thinning than desired, this may increase your risk of developing clots in your blood vessels. It is important that you keep your scheduled visits so that the doctor can detect important changes in your levels.

Loss of Confidentiality: One possible risk is the loss of confidentiality about your medical information. A related possible risk is disclosure of your genetic information that could lead to discrimination against you in insurance or employment. There are some state laws that protect against genetic discrimination by employers or insurance companies, and a federal law protecting against such discrimination will take effect late in 2009. There is the unlikely risk that if people other than the researchers got your genetic information they could misuse it. The chance of this happening to you is very small.

Today, there are a limited number of possible ways of linking genetic information back to you. As research advances, there may be new ways of linking genetic information back to you that we cannot foresee now. Also, since we do not yet know the results of research, new risks may become known in the future that we cannot predict now. These new risks may include genetic associations with disorders other than warfarin dosing. Every attempt will be made to keep all information collected in this study strictly private.

Are there any benefits to taking part in this research study?

A direct benefit cannot be guaranteed. It is possible that, by being in this study, your levels of blood thinning will be improved. This could reduce your chances of having complications from warfarin therapy, reduce your chances of developing blood clots in your blood vessels, or improve the ability to better adjust your warfarin dose, reducing the need for repeat clinic visits.

You will be contributing to scientific knowledge and possibly helping other patients with this condition by what is learned from the study results. By participating in this study, you will be increasing knowledge about how genes work in individuals and how that relates to health and disease.

All of the warfarin that you need for the first 30 days of treatment will be provided by the research study, free of charge. After this time, the study will not be using blinded assignment of warfarin, and you will therefore fill your warfarin prescription like you do any other medications that you are taking.

What happens if you decide not to take part in this research study?

Participation in this research study is voluntary. You do not have to take part in the research project to continue to receive care at [insert name of institution]. If you decide not to take part in this research study, your current and future medical care at [*Insert name of Institution]* will not be affected in any way and you will receive the same standard of heath care given for warfarin therapy.

What if you want to leave the research study after it begins?

Once you start in this research study, you are free to stop at any time. If at any time during the study you choose to withdraw from the study, you will still receive the same health care you would have otherwise received. However, if you stop in the first 4 weeks of the study, the study will not provide your warfarin free of charge. This study is expected to end after all participants have completed the study, and all information has been collected. Your participation in this study may also be stopped at any time by the study doctor or the study Sponsor (NHLBI, NIH), without your consent because:

- The study doctor feels it is necessary for your health or safety. Such an action would not require your consent, but you will be informed if this decision is made, and the reason for this decision.
- New information suggests that taking part in the research study may not be in your best interests.
- You have not followed study instructions.
- The Sponsor or the study doctor has decided to stop the study for any other reason.

Will confidential health information be collected as part of this study?

Yes. We need to collect your health information to conduct this study and we will keep it confidential as required by law.

Authority to Collect Information: The authority to collect this information is under 42 USC [National Heart, Lung, and Blood Institute (NHLBI) – 42 USC 285b]. Federal Privacy Regulations provide safeguards for privacy, security, and authorized access. We will ask you to provide information about your medical conditions, treatments, health habits, and the quality of your life. We will collect medical record information related to any hospitalizations and out-patient treatments you receive while participating in this study. We will also collect information from your billing records on the costs related to any hospitalizations and treatment services.

Every attempt will be made to keep your health information private. [Insert text of site specific protected health information (PHI)]

Personal identifying information such as your name, address, and phone number will be collected. It will be used by the study staff to contact you for study related purposes such as scheduling, or to give you health information. This information will only be available to the local study staff members. Your study information will be

given a unique code number. The key to this unique code will be kept in a locked file or a password-protected computer file at [*insert name of institution*].

The University of Pennsylvania serves as the Clinical Trial Coordinating Center for this research study. All of the study information from the research centers, without your identifying information, will be stored in secure computer files at the University of Pennsylvania by unique code. All study information will be sent to the Coordinating Center by secured internet connection.

To help us protect your privacy, a Certificate of Confidentiality from the National Institutes of Health has been obtained. This Certificate makes it much more difficult to force the researchers to disclose information that may identify you, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative or other proceedings. The researchers will use the Certificate to resist any demands for information that would identify you, except as explained below. The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of federally funded projects.

A Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information. No voluntary disclosure of information that would identify you as a participant in this research study will be made, without your written consent.

Some members of the research project will have permission to see your identifying information in order to ensure that the study is being performed properly. They will be required to keep this information confidential. Authorized representatives of the Sponsor, the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH), and the Institutional Review Board at *(insert name of institution)*, may have access to and may copy medical or research records that identify you by name. This step is necessary to ensure the accuracy of the research findings and your safety and welfare.

During the study, blood samples and your genetic sample will be stored at a Central Laboratory at Washington University in St. Louis, MO under a code number that will not have any personal identifying information. Information about your samples will be kept in a secure computer file that can be used only by authorized staff members.

The results of this study may be shown at meetings or published in journals so other doctors and health professionals know about the study. You will not be identified by name or other personal information in any written publication or presentations about the study. Other researchers who are approved through standard, approved agreements may be permitted to analyze the data without your personal identifying information. This information may include other identifiers such

as dates of medical tests and services, but will not include your name or any other primary identifiers such as address, Social Security number, or Medicare number.

At the end of the study, all forms with your name or other identifying information will be stored in a locked facility at [insert name of institution] for a period of at least XXX [fill in site-specific requirements] years. Only the study doctor or study staff members assisting the doctor will have access to these forms. After XXX five years [to be filled in relevant to institution/State], the forms will be destroyed.

Also at the end of the study, the Coordinating Center will provide to the National Heart, Lung, and Blood Institute (NHLBI) the information collected from the study, without personal identifying information such as your name, address, Social Security number, or Medicare number.

Blood samples taken from you during the study will be considered donated by you to medical research. After the main study has ended, the blood samples will be transferred to a National Heart, Lung, and Blood Institute (NHLBI) laboratory storage center, which saves samples from many research projects around the country to conduct large research studies. Your name or other information that could identify you will not appear on the blood samples.

The study information and/or blood samples may be shared with other scientists who meet NHLBI requirements. These requirements include treating the study information and/or blood samples as medically confidential, obtaining approval from their Human Subjects review boards, and agreeing not to share the information or blood samples with other researchers. NHLBI policies regarding data availability, especially genetic data availability, are subject to change. The investigators will continue to ensure that current NHLBI guidelines are followed.

Study information and blood sample data will be stored in a secure computer file. under a code number that will not have any personal identifying information. The information in this computer file will be available on an Internet database that is available only to researchers who have been approved by the NHLBI and under security standards that are reviewed by researchers and public advocates. Researchers who plan to access coded medical information or other information from the databases will not know who you are nor have access to the code linking genetic data to you.

Only certain study investigators who are working directly with the genetic data will have the master code that links your name with the code number. This master code will be kept in a secure location at [Insert name of institution].

Contacting you about the results of the study

Once the entire study is completed, in about 1 year, you will be informed of the results. At that time, we will contact you by phone to obtain your current mailing address so that we may provide you with a written summary of the study results.

Contacting you about the results of genetic testing

Results of your genetic findings from this research study will not be reported to you unless that information would change your medical care. If we find that you have a genetic condition that may have potentially important meaning for your health and treatment, we will contact you if you have given us consent to do so. Results from genetic testing will not be placed in your medical record, or shared in any way with your relatives, personal physician, or insurance companies, unless you request the research staff, in writing, to do so.

What happens to my health information if I leave the study?

You can leave the study at any time or ask that your health information not be used. If you ask that we no longer collect your health information, then you will have to leave the study.

If you choose to leave the study, but will let the researchers use or share your personal health information, you will be asked to fill out a form, called the "Withdrawal from Study" form.

If you do not want us to collect, use or share your health information anymore, you must send a letter to the study doctor. In the letter, you must say you changed your mind and that you will not allow us to use and share your health information anymore. We will then ask you to fill out a form, called a "Withdrawal of Study Participation and Consent/Authorization" form.

Even if you take back your permission for us to use your information, we may still use the information about you that we collected before you left the study. We do this because we need to know what happens to everyone who starts a research study for the study to be valid.

If you leave the study, you can ask that your blood samples be destroyed. You may also ask that your coded medical and genetic information not be released in the future. However, information that has already been distributed will not be able to be recalled.

Financial Costs and Compensation

You will not have to pay to be in this study. All procedures and tests specifically required by the study (for example the genetic tests) will be covered by the study. However, all other procedures and tests that are part of routine medical care (like the INR tests) will need to be covered by you or your medical insurance.

You will receive payment for your participation in this study. You will receive $50 for completing the initial survey and the first 5 days of the study; $50 for completing first 30 days of the study (from days 6 to 30), $50 for completing the next 2 months of the study (up to the 3 month visit), and $50 for completing the

final 3 months of the study (up to the 6 month visit if you are on warfarin for this period of time). The total will be $200 if you complete your study visits and are in the study for 6 months.

Warfarin, the study medication, will be provided free of charge during the first 4 weeks of your participation in the study. After one month, you or your medical insurance will have to pay for it. [*This section should be customized per site. Parking/transportation reimbursement, if provided, should be itemized*.]

What if I get hurt or ill from my participation?

While it is not likely that you will suffer major health problems as a result of your participation in this study, the medical treatment that is a part of this study carries a small risk of serious health problems. Of course, should a problem occur, or should you need emergency medical help, necessary emergency care would be provided and the investigator working with you would help you find a doctor to continue your care if needed. Any cost of medical care that results from such a health problem will be your responsibility and will not be paid for by the National Heart, Lung, and Blood Institute, the study investigators, or the hospital or clinic conducting this study.

New Information

During the course of this study, we may find more information that could be important to you. This includes information that, once learned, might cause you to change your mind about being in the study. We will notify you as soon as possible if such information becomes known.

Contact Persons for Study

If at any time you have questions, concerns, or comments about this study or experience a research-related injury, you should contact [*Insert Principal Investigator's name*] at [*Insert telephone number*].

Institutional Review Boards/Subject Rights

The ____[*Insert your Institution's name*] has a committee called the Institutional Review Board (IRB). It is their responsibility to make sure that the possible benefits of participating in the study are greater than the possible risks and that people in the study are informed about risks and benefits. If you would like more information or have questions about your rights as a research subject, you can contact the Office of Regulatory Affairs at the _____ by phoning _____. [*Insert appropriate information for your clinical site's IRB*]

Statement of Voluntary Participation

I have read the above information about this research study. I have been given an opportunity to ask questions about it and to discuss it with [*Insert Principal Investigator's name or authorized personnel*]. All of my questions/concerns have been answered to my satisfaction. I understand that I need to contact the [*Insert your Institution's name and telephone number*], if I move or change my telephone number. My signature below indicates my voluntary participation in this research study. It also indicates that no procedures associated with this study have been performed on me prior to my signing this consent.

Alternatives to Participation

Genetic testing to study response to warfarin dosing is a requirement of participation in this study**.** Your alternative is not to participate in this research study. Your warfarin treatment will then be determined according to standard medical care.

Refusal or Withdrawal of Participation

I understand that I may refuse to participate or withdraw from the study at any time without consequence to my present or future care at the [*Insert your Institution's name*].

Documentation of Consent

The original and one copy of this consent form will be kept in a research folder and a copy of this Consent Form will be given to you to keep.

Supplement to the COAG Study Informed Consent

Permission for Future Use of Your COAG Blood Sample and Information Collected in the COAG Study

Introduction

Once your participation in the COAG study has ended, we would like to use your genetic blood specimen (sample) and medical information for future research and we request your permission to do this. Allowing your genetic material and medical information to be used in these future studies is voluntary and you can refuse to participate. You do not have to provide this permission in order to be part of the COAG Study.

What will happen if I agree to future use of my specimen and information?

By signing this form, you will allow the National Institutes of Health (NIH) to store and save your blood sample and data in a "sample bank" on a long-term basis and to make decisions about how your samples and data will be used in the future.

The genome-wide association studies and sequencing studies that will allow COAG researchers to search for all possible genetic changes related to your body's response to warfarin, also provide information that can be used to study many other conditions. This is different from studying genetic changes that might relate to your response to warfarin, which is part of the COAG study.

Your information may be useful for genome-wide association studies or other genetic studies of other conditions. This research may include genetic or biology studies that are not about warfarin therapy. Your blood sample also may be used for genetic testing to study genes or other materials in the blood related to other diseases, such as heart disease. Your blood samples may be shared with scientists from private research companies. Another example for future use of your blood sample would be that one or more laboratories selected by the NIH might study your genetic data to identify possible genetic changes that might be related to a particular condition. More tests could be performed on the sample to find out which of those changes are actually associated with disease. Laboratories participating in these future studies will NOT receive personally identifying information on you; they will only receive coded specimens.

How will my identity be protected?

If you agree to participate in this kind of study, your samples and medical information will be coded (assigned a unique study number) to allow the researchers to link your blood sample to the other information that you provide through the COAG study, such as age, gender, race, diagnosis, disease history, medical treatments. Information that might identify you personally will NOT be provided to the researchers. This information will be saved in a computer file along with information from the other research participants. The information in this computer file will be available on an Internet database that is available only

to NIH-approved researchers and under security standards that are reviewed by researchers and public advocates. Researchers who plan to access coded medical information or other information from the databases will not know who you are nor have access to the code linking genetic data to you.

Researchers who plan to use your genetic material for future scientific study will have to request and receive all of the necessary approvals from the National Institute of Health, National Heart, Lung, and Blood Institute before using your sample. Samples will only be released to scientists who are qualified and prepared to conduct a research study and who will follow the confidentiality policy. NIH policies regarding data availability, especially genetic data availability, are subject to change. The investigators will continue to ensure that current NIH guidelines are followed.

Information obtained from the analysis of future research studies will be anonymous and cannot be used to identify you. Information related to these types of research studies may be put in an open Internet database, which means that it will be available to anyone on the Internet.

What are the risks involved in allowing future use of my genetic specimen and information?

There are no physical risks to you. The main risk is that someone could get access to the data we have stored about you. If that data suggested something serious about your health, it could be misused. For example, it could be used to make it harder for you to get or keep a job or insurance. There are laws against this kind of misuse, but they may not give full protection. We believe that the chance of these things ever happening is extremely small. However, we cannot make guarantees. Your privacy and the confidentiality of your data are very important to us and we will make every effort ot protect them. Your name or any other personally identifying information will NOT be used in any published reports from future research performed on your specimen.

What are the benefits of allowing future use of my genetic specimen and information?

Information gained from research on your blood samples may be used for the development of diagnostic procedures or new treatments for major diseases. Your blood samples will not be sold to any person, institution, or company for financial gain or commercial profit. However, neither you nor your heirs will gain financially from discoveries made using the information and/or specimens that you provide. There will be no direct benefit to you from allowing your specimen to be kept and used for future research.

Contacting you in the future

We can only use your information again if special committees called the Institutional Review Boards, let us. These committees may want us to talk to you again before we do another study using your information, or the committees may also let us do research without talking to you again if we keep your health information private. If

these committees do require us to talk to you again, we will attempt to re-contact you to give you an opportunity to participate in future studies that are approved by these committees. You may tell us that you do not wish to be re-contacted. You may also tell us that you do not want us to use your specimen (sample) and information in future studies.

Agreement to Participate in the COAG Study

Instructions: For each permission, please **CIRCLE *"YES"*** or ***"NO"*** and write your initials and today's date in each row where indicated.

1. I agree to participate in the COAG study, which includes the use of genetic data and measurements of other factors in the blood to study my response to warfarin dosing.

YES Initials: _____ Date: _____ ***NO*** Initials: _____ Date: _____

2. I understand that the genetic data collected from me are considered research results. If the research results suggest that I have a genetic condition that may have potentially important meaning for my health and treatment, *I agree to allow the COAG study to notify me and with my permission to notify my physician.*

YES Initials: _____ Date: _____ ***NO*** Initials: _____ Date: _____

Agreement for Future Use of My COAG Blood Sample and Information Collected in the COAG Study

Instructions: For each permission, please **CIRCLE *"YES"*** or ***"NO"*** and write your initials and today's date in each row where indicated.

1. I give permission to study my genetics and other biological factors for other health conditions besides response to warfarin therapy.

YES Initials: _____ Date: _____ ***NO*** Initials: _____ Date: _____

2. *I agree to allow future studies to make my genetic and other information available on a controlled access website to approved researchers. Such information cannot be used to identify me. I give permission to have my coded genetic information and coded medical information placed in this special database for use only by approved researchers.*

YES Initials: _____ Date: _____ ***NO*** Initials: _____ Date: _____

3. *I agree to allow researchers from private companies to have access to my DNA and genetic data which may be used to develop laboratory tests or pharmaceutical therapies that could benefit other people.*

YES Initials: _____ Date: _____ ***NO*** Initials: _____ Date: _____

6. *I give permission to be contacted in the future to see if I am willing to provide additional biological samples or follow-up information about my health or medical care.*

YES Initials: _____ Date: _____ ***NO*** Initials: _____ Date: _____

SIGNATURES

I have read and received a copy of this consent form. I understand that my signature below means that I voluntarily agree to participate in this study.

Printed Name	Signature of Participant	Date

Complete ONLY if patient is unable to sign:

Printed Name of Legally Authorized Representative	Signature of Legally Authorized Representative _____ (Note relationship with participant)	Date

Completed ONLY if patient or their legal representative is unable to read this consent form and an impartial witness is present for the entire discussion:

Printed Name	Signature of Witness	Date

I certify that I have discussed the study purpose, potential benefits, and risks with the below named participant and/or his/her authorized representative, using language that is understandable and appropriate. I have answered any questions that have been raised and have witnessed the signature of this subject. I have explained the information contained in this document to the subject on the date stated on this consent form.

Printed Name	Signature of Person Obtaining Consent	Date