Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***[Name of physician]*** is offering to treat you, your child (in which case the word “you” will refer to “your child” throughout this document), or your representative (in which case the word “you” will refer to the person you are representing) with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***[Name of unapproved drug, device, or biologic]*** because you have a serious condition called \_\_\_\_\_\_\_\_\_\_\_\_ and there are no standard acceptable options.

## What you should know about this experimental treatment

1. This treatment has not been approved by Food and Drug Administration.
2. This treatment is considered experimental and research. [delete “and research” for uses of devices]
3. Someone will explain this treatment to you.
4. You volunteer to get this treatment.
5. Whether or not you get this treatment is up to you.
6. You can choose not to get this treatment.
7. You can agree to get this treatment now and later change your mind.
8. If you do change your mind, contact your doctor right away.
9. Whatever you decide it will not be held against you.
10. Feel free to ask all the questions you want before you decide.

## How long will this experimental treatment last?

We expect that the experimental treatment will last \_\_\_\_\_\_\_\_ [hours/days/months/weeks/years, until a certain event].

## What happens if I get this experimental treatment?

[Tell the patient what to expect using lay language and simple terms.]

## Is there any way this experimental treatment could be bad for me?

[Describe the risks of the treatment]

This treatment may hurt you in ways that are unknown. These may be a minor inconvenience or may be so severe as to cause death.

If you are or become pregnant, this treatment may hurt your baby or your pregnancy in ways that are unknown. These may be a minor inconvenience or may be so severe as to cause death.

Getting this treatment may lead to added costs to you. You and your insurance company will be charged for the health care services that you would ordinarily be responsible to pay. Insurance may not pay for this treatment because it is considered experimental.

## Can this experimental treatment help me?

We cannot promise that this treatment will benefit. The goal of this treatment is to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. [Describe the potential benefits of the treatment]

## What else do I need to know?

Efforts will be made to limit your personal information, including medical records, to people who have a need to review this information. We cannot promise complete secrecy. Institutions that may inspect and copy your information include the IRB, representatives of this institution, and the Food and Drug Administration. [NOTE: HIPAA Authorization is not required because this does not meet the HIPAA definition of research.]

It is important that you promptly tell the person in charge of the research if you believe that you have been injured because of taking part in this study. If you are injured as a result of being in this study, the University of California will provide necessary medical treatment. The costs of the treatment may be covered by University or the study sponsor or may be billed to your insurance company just like other medical costs. The University and the study sponsor do not normally provide any other form of compensation for injury. For more information about compensation, you may call the IRB Administration at (916) 703-9158 or email at hs-irbeducation@ucdavis.edu.

## Who can I talk to?

If you have questions, concerns, or complaints, or think the treatment has hurt you talk to your doctor at \_\_\_\_\_\_\_\_\_\_\_\_ [Insert contact information]

This treatment is subject to oversight by an Institutional Review Board. Information to help you understand research is on-line at <https://irb.ucdavis.edu/for-research-participants/>. If you have questions about your rights or any unresolved question, concern, or complaint, talk to representatives of the Institutional Review Board at (916) 703-9158, hs-irbeducation@ucdavis.edu, or 2921 Stockton Blvd, Suite 1400, Room 1429, Sacramento, CA 95817.

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| Your signature documents your permission to take part in this experimental treatment. |
|  |  |  |
| Signature of patient, legally authorized representative, parent, or guardian of a child |  | Date |
|  |  |
| Printed name of patient |
|  |  |  |
| Signature of person obtaining consent |  | Date |
|  |  |  |
| Printed name of person obtaining consent |  |  |