

**CONSENT TO MEDICAL TREATMENT**

**CLL4 TRIAL:  
A RANDOMISED COMPARISON OF CHLORAMBUCIL,  
FLUDARABINE AND FLUDARABINE PLUS CYCLOPHOSPHAMIDE**

**MREC No: 98/101**

**Local Ethics Committee No:**

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**TO BE SIGNED BY DOCTOR**

I confirm that I have explained the proposed treatment, possible risks and benefits and such appropriate options as are available to the patient in terms which in my judgment are suited to his/her understanding. I have also provided the patient with a detailed written information sheet describing this trial.

Signature ..... Date ..... / ..... / .....

Name of doctor .....

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**TO BE SIGNED BY PATIENT** (Please read the following very carefully)

The doctor has explained the proposed treatment which is outlined in the patient information sheet. You can ask any questions and seek further information. If there is anything that you don't understand about the explanation, or if you want more information, you should ask the doctor. You are entitled to refuse the treatment or withdraw your consent at any time.

I consent to participate in this trial, which has been explained to me by the doctor named on this form and that my GP should also be informed.

I understand that my participation is entirely voluntary and that any procedure in addition to the treatment described on this form will be carried out only if it is in my best interests and can be justified for medical reasons, and that blood samples taken in the clinic may be used for research purposes.

Please check that all the information on the form is correct. If you understand the explanation and are willing to proceed, then sign the form below.

Signature .....

Name .....

Address.....  
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