



Name of Local Researcher:

*Professor Paul Little, Professor of Primary Care, Department of Primary Medical Care
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CONSENT TO CONTACT FORM

DUTY: The Diagnosis of Urinary Tract Infection (UTI) in Young Children Study

I agree that my contact details as given below can be given (in person or by telephone or secure fax) to the researchers carrying out the DUTY study. This will enable them to contact me and arrange a time/place to explain the study in more detail so that I can then decide whether or not to take part.

BLOCK CAPITALS PLEASE:

Name of Child: _____

Name of Parent / Guardian: _____
(Mr/Mrs/Miss/Ms, Forename, Surname)

Address: _____

Postcode: _____

Main contact number: _____

Alternative contact number: _____

Signature of Parent / Guardian: _____

Date: _____ / _____ /20_____