



Participant Code: PF ____



La Trobe Sports and Exercise Medicine Research Centre
Consent form for persons participating in research projects

LTU ethics approval number HEC17-080

The physiotherapy for Femoroacetabular Impingement Rehabilitation Study (PhysioFIRST): A participant and assessor-blinded randomised controlled trial of physiotherapy for hip impingement.

Investigators: Dr Joanne Kemp, Sally Coburn, Denise Jones, Dr Anthony Schache, Dr Benjamin Mentiplay
 Associate Professor Dr Steven McPhail, Professor Kay Crossley

I, _____, have read and understood the **participant information statement and consent form**, and any questions I have asked have been answered to my satisfaction. I understand that even though I agree to be involved in this project, I can withdraw from the study at any time, up to four weeks following the completion of my participation in the research. Further, in withdrawing from the study, I can request that no information from my involvement be used. I agree that research data provided by me or with my permission during the project may be included in a thesis, presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used.

I consent to my data being included in other research projects. I acknowledge that my data will be coded, but can be potentially identified. Yes No

I consent to my single leg squat test being videoed. I acknowledge that any video data will be de-identified. Yes No

I understand my participation will not affect my current or future staff/student affiliation/physiotherapy management with: Yes No

I consent to be involved in the additional testing of physical activity using the Fitbit device Yes No

I consent to be involved in the additional testing of my movement patterns through biomechanical assessment Yes No

I consent to be involved in the additional testing of hip joint structure via Magnetic Resonance Imaging (MRI) scans Yes No

I wish to have a summary report sent to me at the conclusion of my participation in this project. Yes No



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Last Name:	Given Name:	
DOB:	Age:	Contact Phone number:
Address:		
Signature:	Date:	
Witness name:	Date:	
Investigator:	Date:	

Name and phone number of contact person in case of an emergency:

Name:	Phone:
Family Doctor:	Phone: