

# University of Michigan

## Consent To Be Part Of A Research Study

### INFORMATION ABOUT THIS FORM

You, or your child, may be eligible to take part in a research study. This form gives you important information about the study. It describes the purpose of the study, and the risks and possible benefits of participating in the study. Parents or legal guardians, who are giving permission for a child, please note: in the sections that follow the word 'you' refers to 'your child.'

Please take time to review this information carefully. After you have finished, you should talk to the researchers about the study and ask them any questions you have. You may also wish to talk to others (for example, your friends, family, or other doctors) about your participation in this study. If you decide to take part in the study, you will be asked to sign this form. *Before you sign this form, be sure you understand what the study is about, including the risks and possible benefits to you.*

(This document was prepared in December, 2007.)

### 1. GENERAL INFORMATION ABOUT THIS STUDY AND THE RESEARCHERS

#### 1.1 Study title:

Mutation analysis in nephrotic syndrome and glomerulonephritis, and cloning of new genes for nephrotic syndrome

#### 1.2 Company or agency sponsoring the study:

NIH (National Institute of Health) 5P50-DK039255-20, NIH 1R01-DK076683-01A1  
Thrasher foundation 05-4955

#### 1.3 Names, degrees, and affiliations of the researchers conducting the study:

Friedhelm Hildebrandt, MD	Principal Investigator	U of M Pediatric Nephrology
Roger Wiggins, MD	Co-Investigator	U of M Internal Medicine
Bernward Hinkes, MD	Co-Investigator	U of Erlangen, Germany, Pediatrics
Christopher Vlangos, PhD	Co-Investigator	U of M Pediatric Genetics
Susan Allen, MS	Co-Investigator	U of M Pediatric Nephrology
Saskia Heeringa, MD	Co-Investigator	U of M Pediatric Nephrology
John O'Toole, MD	Co-Investigator	Case Western, Ohio, Internal Med
Shazia Ashraf, MS	Co-Investigator	U of M Pediatric Nephrology
Hassan Chaib, PhD	Co-Investigator	U of M Pediatric Nephrology
Gil Chernin, MD	Co-Investigator	U of M Pediatric Nephrology
Bugsu Ovunc, MD	Co-Investigator	U of M Pediatric Nephrology
Virginia Vega-Warner, PhD	Co-Investigator	U of M Pediatric Nephrology

### 2. PURPOSE OF THIS STUDY

#### 2.1 Study purpose:

Nephrotic syndrome (NS) is one of the most common kidney diseases. The purpose of this research is to identify genes that can cause nephrotic syndrome.

### 3. INFORMATION ABOUT STUDY PARTICIPANTS (SUBJECTS)

Taking part in this study is completely **voluntary**. You do not have to participate if you don't want to. You may also leave the study at any time. If you leave the study before it is finished, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled.

#### 3.1 Who can take part in this study?

Anybody with nephrotic syndrome, as determined by a kidney specialist and first degree family members (i.e. siblings, parents or children) of these individuals are eligible to participate in this study. In cases in which the parents of the affected individual are consanguineous (i.e. they share a blood relationship) more distantly related family members may be considered eligible for the study.

*Note: It is very **important** for you to give the researchers **accurate** and **complete** information about your medical history and condition.*

#### 3.2 How many people (subjects) are expected to take part in this study?

3,000 subjects are expected to participate, 200 at the University of Michigan and 500 at other sites around the United States, 2,300 will be from world wide sources.

### 4. INFORMATION ABOUT STUDY PROCEDURES

#### 4.1 What exactly will be done to me in this study? What kinds of research procedures will I receive if I agree to take part in this study?

In order to enroll in this study you must review this document with your doctor. If you agree to be a research subject in this study, your physician will provide information to us about your previous loss of protein by the kidney and any other relevant medical history and laboratory results that you may have had done already as a part of your health care to this point. If other members of your family are also affected by the disease, we kindly ask you to inform them of our study and we will provide you information to give them. Interested eligible family members can give us permission to contact them by sending a postcard to us that we will provide to you.

Finally, a blood sample will be obtained from a vein in your arm using the same procedures as for standard blood tests. The total amount of blood collected of an adult will correspond with approximately 4 teaspoons (corresponding 20 ml), the total amount of blood collected of a child will correspond with approximately 2 teaspoons (corresponding 10 ml).

Alternatively, we will ask you to collect cells from inside of your child's mouth and we will obtain DNA samples from the cells. To collect the cells we have provided you with a small brush known as a CytoSoft brush. The collection takes about 30 seconds and will not hurt. In order to collect good DNA it is best to collect the cells first thing in the morning before eating, drinking, and brushing teeth. It is especially important that no tea, coffee, or soda pop is consumed before the sample is taken.

Instructions for collection:

1. Unwrap the mouth swab by peeling at the arrow, and remove brush from packaging.
2. Place the brush in your mouth between your teeth and the inside of your cheek.

3. Run the swab firmly backwards and forwards along your cheek and in between the cheek and gum. This should be done for 30 seconds. Please time it. It is longer than you think! **There is no need for force, do not brush so hard that you bleed.**
4. When you have finished, replace the swab in the package (the used end goes in first).
5. Please send brushes along with any paperwork (for example, completed questionnaire and/or signed consent forms) in the envelope provided.
6. If you have further questions/clarification, please call the study coordinator.

We will then test your sample on mutations in genes known to cause nephrotic syndrome. If you are known to have kidney disease as determined by your doctor, a report of the results of genetic testing for nephrotic syndrome can be sent to your doctor if you wish. These results are part of a research study and not part of a certified laboratory testing. All samples received will be saved indefinitely, unless the participant withdraws from the study. If you do not have a mutation in a known gene, we will perform further studies to identify new disease causing genes as part of this research project. This type of research can take years, if you develop kidney disease after enrolling in the study you are encouraged to inform the investigators of this change and you would be eligible to receive results of genetic testing if you desired them.

In case tissue of your kidney has been removed in the course of your disease, we ask you for permission to obtain a sample from your doctor. Please note that this procedure does not require any additional involvement of you, if you agree to the analysis of your tissue at the end of this form.

This research project is designed to identify the causes of nephrotic syndrome. The cost of office visits to local physicians or genetic counselors are not covered by this study; nor are any testing other than the blood draw for the DNA sample requested by this study.

As new knowledge on the causes of nephrotic syndrome becomes available, new ideas for research projects might arise. Therefore, you will have the opportunity to let us know at the end of this document, whether or not you agree to let us use your samples for future related studies. New studies will follow the same strict ethic guidelines for your protection as this study.

#### **4.2 How much of my time will be needed to take part in this study? When will my participation in the study be over?**

To participate in this study a single visit is required to complete this consent form and to draw blood. In rare cases (e.g. because of problems with processing the sample), a second visit to draw an additional blood sample might be necessary. This will take approximately one hour. The DNA taken from the blood sample will be stored indefinitely for the evaluation of the genetic causes of nephrotic syndrome exclusively as described in this document.

#### **4.3 When will my participation in the study be over?**

As stated above (see question 4.2), the DNA taken from the blood sample will be stored indefinitely for the evaluation of the genetic causes of nephrotic syndrome exclusively as described in this document.

## 5. INFORMATION ABOUT RISKS AND BENEFITS

### 5.1 What risks will I face by taking part in the study? What will the researchers do to protect me against these risks?

The known or expected risks are:

- The risks for a routine venous blood draw which include discomfort, bruising, faintness or lightheadedness and very rarely infection.
- The risk for identifying a genetic cause of disease can include difficulty in obtaining insurance or increased cost of insurance. However, since insurance companies do not cover the costs for genetic testing, blood draws for genetic testing or shipping and handling of the blood for genetic testing in this study they are not entitled to the results of this study. The investigators will not disclose any findings of this study to anyone other than the participant's private physician. If desired the researchers will not report any results to the participant's private physician.
- The risk for learning of a genetic cause of disease may cause the participant emotional distress which could result in depression or anxiety. We hope to minimize distress caused by this information as we report only for individuals who are already aware that they have kidney disease and therefore, this information will only provide a definitive diagnosis for people who are already known to have kidney disease.

As with any research study, there may be additional risks that are unknown or unexpected.

- The blood draw will be performed in a controlled environment using antiseptic technique. Your insurability will not be jeopardized by the investigators, as no information from this study is shared with anyone other than the participant's private physician if so desired.
- Please consider the emotional impact that receiving the results of this study will have for you. Your participation in this study does not require that the results of the study be reported to your physician. If you do not understand potential ramifications of learning the results of this study you are encouraged to discuss these with your local physician, the investigators or obtain genetic counseling prior signing this consent and enrolling in the study. This study does not cover the costs of genetic counseling or physician visits to review or discuss results of this study before or after results become available.

### 5.2 What happens if I get hurt, become sick, or have other problems as a result of this research?

The researchers have taken steps to minimize the risks of this study. Even so, you may still have problems or side effects, even when the researchers are careful to avoid them. Please tell the researchers listed in Section 10 about any injuries, side effects, or other problems that you have during this study. You should also tell your regular doctors.

The University of Michigan will provide first aid or emergency care. Additional medical care will be provided if the University determines that it is responsible to provide such treatment. If you sign this form, you do not give up your right to seek additional compensation if you are harmed as a result of being in this study.

### 5.3 If I take part in this study, can I also participate in other studies?

*Being in more than one research study at the same time, or even at different times, may increase the risks to you. It may also affect the results of the studies.* You should not take part in more than one study without approval from the researchers involved in each study.

**5.4 How could I benefit if I take part in this study? How could others benefit?**

You may not receive any personal benefits from being in this study. Some people find satisfaction in contributing to scientific knowledge about genetic problems and their medical consequences. Others could benefit in the future by improved diagnostic and therapeutic procedures.

**5.5 Will the researchers tell me if they learn of new information that could change my willingness to stay in this study?**

Yes, the researchers will tell you if they learn of important new information that may change your willingness to stay in this study. If new information is provided to you after you have joined the study, it is possible that you may be asked to sign a new consent form that includes the new information.

**6. OTHER OPTIONS****6.1 If I decide not to take part in this study, what other options do I have?**

If you do not want to participate in this study, there will be no penalty. In this case, we cannot offer you genetic testing for nephrotic syndrome. Ask your doctor about other options you may have.

**7. ENDING THE STUDY****7.1 If I want to stop participating in the study, what should I do?**

You are free to leave the study at any time. If you leave the study before it is finished, there will be no penalty to you, and you will not lose any benefits to which you may otherwise be entitled. If you choose to tell the researchers why you are leaving the study, your reasons for leaving may be kept as part of the study record. If you decide to leave the study before it is finished, please notify one of the persons listed in Section 10 "Contact Information" (below). Samples without identifiers might still be retained for research. When this study ends, samples will be stripped of information or codes that could identify you and the samples then stored for use in other studies in an anonymous fashion, or the samples may be properly disposed of.

**7.2 Could there be any harm to me if I decide to leave the study before it is finished?**

No

**7.3 Could the researchers take me out of the study even if I want to continue to participate?**

Yes. There are many reasons why the researchers may need to end your participation in the study. Some examples are:

- ✓ The researcher believes that it is not in your best interest to stay in the study.
- ✓ You become ineligible to participate.
- ✓ The study is suspended or canceled.

## 8. FINANCIAL INFORMATION

### 8.1 Will taking part in this study cost me anything? Will I or my insurance company be billed for any costs of the study? If so, which costs? What happens if my insurance does not cover these costs?

There are no costs or billing for this study.

### 8.2 Will I be paid or given anything for taking part in this study?

No. You will not be paid for taking part in this study.

### 8.3 Who could profit or financially benefit from the study results?

No person or organization has a financial interest in the outcome of this study.

## 9. CONFIDENTIALITY OF SUBJECT RECORDS AND AUTHORIZATION TO RELEASE YOUR PROTECTED HEALTH INFORMATION

The information below describes how your privacy and the confidentiality of your research records will be protected in this study.

### 9.1 How will the researchers protect my privacy?

Your blood sample will be coded and the code list securely stored and accessible only to members of the investigative team. If there is a medical reason to seek specific information from you in the future, your doctor will tell you about this. When results are shared with other scientists no names or other information which could be used to identify the participant will be shared.

### 9.2 What information about me could be seen by the researchers or by other people? Why? Who might see it?

Signing this form gives the researchers your permission to obtain, use, and share information about you for this study, and is required in order for you to take part in the study. Information about you may be obtained from any hospital, doctor, and other health care provider involved in your care, including:

- Hospital/doctor's office records, including test results (X-rays, blood tests, urine tests, etc.)
- Mental health care records (except psychotherapy notes not kept with your medical records)
- Alcohol/substance abuse treatment records
- Your AIDS/HIV status
- All records relating to your condition, the treatment you have received, and your response to the treatment
- Billing information

There are many reasons why information about you may be used or seen by the researchers or others during or after this study. Examples include:

- The researchers may need the information to make sure you can take part in the study.
- The researchers may need the information to check your test results or look for side effects.
- University, Food and Drug Administration (FDA), and/or other government officials may need the information to make sure that the study is done in a safe and proper manner.

- Study sponsors or funders, or safety monitors or committees, may need the information to:
  - Make sure the study is done safely and properly
  - Learn more about side effects
  - Analyze the results of the study
- Insurance companies or other organizations may need the information in order to pay your medical bills or other costs of your participation in the study.
- The researchers may need to use the information to create a databank of information about your condition or its treatment.
- Information about your study participation may be included in your regular UMHS medical record.
- Federal or State law may require the study team to give information to government agencies. For example, to prevent harm to you or others, or for public health reasons.

The results of this study could be published in an article, but would not include any information that would let others know who you are.

### **9.3 What happens to information about me after the study is over or if I cancel my permission?**

As a rule, the researchers will not continue to use or disclose information about you, but will keep it secure until it is destroyed. Sometimes, it may be necessary for information about you to continue to be used or disclosed, even after you have canceled your permission or the study is over. Examples of reasons for this include:

- To avoid losing study results that have already included your information
- To provide limited information for research, education, or other activities (This information would not include your name, social security number, or anything else that could let others know who you are.)
- To help University and government officials make sure that the study was conducted properly

As long as your information is kept within the University of Michigan Health System, it is protected by the Health System's privacy policies. For more information about these policies, ask for a copy of the University of Michigan Notice of Privacy Practices. This information is also available on the web at <http://www.med.umich.edu/hipaa/npp.htm>. Note that once your information has been shared with others as described under Question 9.2, it may no longer be protected by the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **9.4 When does my permission expire?**

Your permission expires at the end of the study, unless you cancel it sooner. You may cancel your permission at any time by writing to the researchers listed in Section 10 "Contact Information" (below).

## 10. CONTACT INFORMATION

### 10.1 Who can I contact about this study?

Please contact the researchers listed below to:

- Obtain more information about the study
- Ask a question about the study procedures or treatments
- Report an illness, injury, or other problem (you may also need to tell your regular doctors)
- Leave the study before it is finished
- Express a concern about the study

Principal Investigator: Friedhelm Hildebrandt, MD  
Mailing Address: University of Michigan Medical Center  
Department of Pediatrics and Communicable Diseases  
1150 W. Medical Center Drive  
MSRB III, Room 8220C  
Ann Arbor, MI 48109-5646  
Telephone: 734-615-7285  
e-mail: [mutation@renalgenes.org](mailto:mutation@renalgenes.org)

Study Coordinator: Gil Chernin, MD  
Mailing Address: University of Michigan Medical Center  
Department of Pediatrics and Communicable Diseases  
1150 W. Medical Center Drive  
MSRB III, Room 8220  
Ann Arbor, MI 48109-5646  
Telephone: 734-764-7145  
e-mail: [mutation@renalgenes.org](mailto:mutation@renalgenes.org)

You may also express a concern about a study by contacting the Institutional Review Board listed below, or by calling the University of Michigan Compliance Help Line at 1-888-296-2481.

University of Michigan Medical School Institutional Review Board (IRBMED)  
Argus I  
517 W. William  
Ann Arbor, MI 48103-4943  
Telephone: 734-763-4768  
Fax: 734-615-1622  
E-mail: [irbmed@umich.edu](mailto:irbmed@umich.edu)

If you are concerned about a possible violation of your privacy, contact the University of Michigan Health System Privacy Officer at 1-888-296-2481.

*When you call or write about a concern, please provide as much information as possible, including the name of the researcher, the IRBMED number (at the top of this form), and details about the problem. This will help University officials to look into your concern. When reporting a concern, you do not have to give your name unless you want to.*

**11. RECORD OF INFORMATION PROVIDED**

**11.1 What documents will be given to me?**

Your signature in the next section means that you have received copies of all of the following documents:

- This "Consent to be Part of a Research Study" document. *(Note: In addition to the copy you receive, copies of this document will be stored in a separate confidential research file and may be entered into your regular University of Michigan medical record.)*
- Other (specify):\_\_\_\_\_

**12. SIGNATURES**

**Research Subject:**

*I understand the information printed on this form. I have discussed this study, its risks and potential benefits, and my other choices with\_\_\_\_\_. My questions so far have been answered. I understand that if I have more questions or concerns about the study or my participation as a research subject, I may contact one of the people listed in Section 10 (above). I understand that I will receive a copy of this form at the time I sign it and later upon request. I understand that if my ability to consent for myself changes, either I or my legal representative may be asked to re-consent prior to my continued participation in this study.*

Signature of Subject:\_\_\_\_\_ Date:\_\_\_\_\_

Name (Print legal name):\_\_\_\_\_

Patient ID:\_\_\_\_\_ Date of Birth:\_\_\_\_\_

If a **result** is obtained by the research:

Yes, I want to know the result  \_\_\_\_\_ (Please initial)

No, I do NOT want to know the result  \_\_\_\_\_ (Please initial)

**Kidney Tissue:**

Yes, kidney tissue has been obtained in the course of my disease and I agree that that tissue is used for further investigations.  \_\_\_\_\_ (Please initial)

No, I do NOT want my tissue samples to be used in the course of this project.  \_\_\_\_\_ (Please initial)

**Future Specimen Use:**

Yes, I agree to have my samples used in future related research projects on nephrotic syndrome.  \_\_\_\_\_ (Please initial)

No, I do NOT want to have my samples used in future related research projects on nephrotic syndrome.  \_\_\_\_\_ (Please initial)

**Legal Representative (if applicable):**

Signature of Person Legally

Authorized to Give Consent: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Print legal name): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Check Relationship to Subject:

Parent  Spouse  Child  Sibling  Legal Guardian  Other: \_\_\_\_\_

**If this consent is for a child who is a ward of the state (for example a foster child), please tell the study team immediately. The researchers may need to contact the IRBMED.**

Reason subject is unable to sign for self: \_\_\_\_\_

**Principal Investigator (or Designee):**

*I have given this research subject (or his/her legally authorized representative, if applicable) information about this study that I believe is accurate and complete. The subject has indicated that he or she understands the nature of the study and the risks and benefits of participating.*

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

**Witness (optional):**

*I observed the above subject (or his/her legally authorized representative, if applicable) sign this consent document.*

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_