**Patient/legal representative consent form for QRNS quality registration**

I have:

* read the enclosed patient information letter,
* discussed the relevant registration with the doctor,
* had the opportunity to ask questions, and
* well understood what the registration and the associated research entails.

I understand that participation in this registration is voluntary and that I can withdraw from this registration at any time without giving any reason. Participation or discontinuing participation will not affect the further treatment I will receive from my doctor(s).

I understand that the information I provide will be processed and analyzed in the manner necessary for the purpose of this registration (improving the quality of neurosurgical care) and

is in accordance with the Medical Treatment Contracts Act (Wgbo) and the statutory rules on the protection of personal data.

I consent to the storage of my pseudonymised and anonymized medical data, which are only visible to persons directly involved in this registration. These persons have a duty of confidentiality. If additional research will take place, I will be asked for permission again. I understand that I may be approached for permission to do so in the future.

I declare that I want to participate in this registration and the associated research. Signing this form does not affect my legal rights.

I consent to access to my relevant medical data by employees of authorities charged with the control of medical research, provided that they keep my name confidential.

I declare that I agree with the use of my anonymised data for the purpose of drawing up a general annual report that can also be made available to organizations that have a task in the field of quality improvement of healthcare.

Patient name: ……………………………………………………………

Gender M / F

Date of birth: …… - ……. - ……………. (day month year)

E-mail address ……………………………………………………………

Name of legal representative (if applicable): ………………………………………………………….

Signature: ……………………………………………………………

Date: …… - ……. - ……………. (day month year)

I have explained the content and purpose of this registration to the above patient.

He/she understands the information and has been given the opportunity to ask questions.

Neurosurgeon name: ………………………………………………………………

Hospital name: ………………………………………………………………

Signature: ………………………………………………………………

Date: …… - ……. - ……………. (day month Year)