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***(Form to be printed on local headed paper)***

**Metoclopramide for Avoiding Pneumonia after Stoke (MAPS-2) study**

**Legal Representative Information and Consent Form**

**(Final version 1.0: 08/11/2021)**

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| ANd9GcRMW58fNpcpk6vdsxCAdA4_4C27yrMjgyXeAwmHPOS_kztWfz3HvQ | **What is this about?**   * This study will test whether metoclopramide (an anti-sickness medicine) can prevent pneumonia and death in patients who have had a stroke |
| ANd9GcSsQ5GaU2tdM32L5OH6CAYEQxw_geDDGCFO4st4mhRe9QW4_mW3 | **Whilst your friend / relative is in hospital:**   * The doctor or nurse will ask them a few questions, and will test their swallowing, speech, eyesight, head, arms and legs to find out how the stroke has affected them. * They may then have a scan of their head and blood tests. * They will be given treatment for their stroke. * Research staff will discuss the study with you and can answer any questions you may have. |
| [https://encrypted-tbn2.gstatic.com/images?q=tbn:ANd9GcRBl0_JbYm4XSBawoMTlunp5uPkmfa3MQRV4sMPL1qUAqcSvfw](http://www.google.co.uk/imgres?imgurl=http://thumbs.dreamstime.com/z/man-hospital-bed-2707913.jpg&imgrefurl=http://www.dreamstime.com/photos-images/sick-man-bed.html&h=1334&w=1300&tbnid=xfK-pmNGa9ZyxM:&zoom=1&docid=qTBHh-WJhNeO6M&ei=Ag5vVKyyK8vdasXcgagI&tbm=isch&ved=0CGgQMygsMCw&iact=rc&uact=3&dur=1819&page=2&start=20&ndsp=25) | **If you agree for them to take part in the study:**   * If your relative is a woman of childbearing age and may be pregnant, with permission we would do a pregnancy test. * They will then be assigned at random to take either the trial treatment or a dummy treatment. They will not know which treatment they are receiving. * They will be given the treatment 3 times a day for 2 weeks or until they are discharged. |
| ANd9GcQJdG4mPmc3Q17xRMVmW9i8srKEuCTtAvmOdUGwzrmVWW62wnbL9A | **2 weeks and 6 months after their stroke:**   * For the first 2 weeks research staff will record details of their condition, their test results and what medication they are taking. * A researcher will call them after 6 months to see how they are, whether they have had any problems and how well they have recovered. |
|  | **Risks**   * The side-effects are generally mild but include drowsiness, diarrhoea, low blood pressure and feeling of weakness, all of which can be treated. |
| ANd9GcRMW58fNpcpk6vdsxCAdA4_4C27yrMjgyXeAwmHPOS_kztWfz3HvQ | **During the study:**   * If you have any questions, then please ask. * You may decide you do not want them to take part anymore. This will not affect any of their care now or in the future. * All the information we hold about them will be kept in the strictest confidence. |

**Metoclopramide for Avoiding Pneumonia after Stoke (MAPS-2) study**

**IRAS Project ID: 290474 ISRCTN4 0512746 CTA ref : 03057/0075/001-0001**

**Name of Researcher**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I confirm that I have been given a copy of the Legal Representative Information Sheet (Version *1.0* and I agree:

* My friend / relative to take part in the MAPS-2 study.
* My friend / relative will have a pregnancy test if deemed necessary because they are of a childbearing age.
* For my friend’s / relative’s medical records to be accessed.
* For my friend / relative to be followed up for 2 weeks and at 6 months
* For my friend’s / relative’s GP to be informed of their participation and to provide information on their status before the telephone follow up.
* For my friend’s / relative’s contact details to be collected and used for the purpose of the study.
* For my friend’s / relative’s information held by NHS digital and other UK NHS bodies may be used to help contact them or provide information about their health.

I understand that I am free to withdraw my friend / relative from the study at any point without giving a reason.

**Legal Representative Consent**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Name of Participant

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Legal Representative Date Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Relationship to Participant

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Person taking consent Date Signature

3 copies: 1 for participant/relative, 1 for the project notes and 1 for the medical notes