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

**LEGAL REPRESENTATIVE TELEPHONE CONSENT FORM**

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

**Title of Study: Metoclopramide for Avoiding Pneumonia after Stroke (MAPS-2) Trial**

**IRAS Project ID: 290474 ISRCTN:40512746 CTA ref : 03057/0075/001-0001**

**Name of Researcher**:

**Please tick box once verbally agreed:**

**Name of Legal Representative:**

**Name of Participant:**

1. I, the above-named legal representative, have been consulted about the above-named participant’s participation in this research project. I confirm that I have read and understand the Legal Representative Information Sheet version number 1.0 dated 08/11/2021 for the above study and have had the opportunity to ask questions.

2. I understand that I can request they are withdrawn from the study at any time, without giving any reason, and without their medical care or legal rights being affected. I understand that should I withdraw them from the study then the information collected so far cannot be erased and that this information may still be used in the project analysis.

3. I understand that relevant sections of their medical records and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to them taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from their participation in this study. I understand that their personal details will be kept confidential.

4. I understand that the information held and maintained by NHS Digital, EDRIS and other central UK NHS bodies may be used to help contact you to provide information about my relative’s / friend’s / the patient’s I have been asked to provide independent physician consent for health status.

5. I agree to the information collected about my relative / friend / patient I have been asked to provide independent physician consent for in this study being used to support other research in the future and be shared anonymously with other researchers.

6.I agree to my relative’s / friend’s / the patient’s I have been asked to provide independent physician consent for GP being informed of their participation in this study and will be asked to provide information on their status before they are contacted for the 6 month follow up.

7. I agree to you sending my relative / friend / the patient I have been asked toprovide independent physician consent for a letter/email with a summary of the study.

YES / NO

8. I understand that pregnancy would exclude participation and agree that a pregnancy test can be performed if appropriate.

9. I agree to signing a consent form on behalf of my relative / friend / the patient I have been asked to provide independent physician consent for when I next attend the hospital.

10. In my opinion they would have no objection to taking part in the above study.

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

Name of Participant

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

Name of Legal Representative Relationship to Participant

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

Name of Person taking consent Date Signature

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

Name of Independent Witness Date Signature

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

Role of Independent Witness

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