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

**PARTICIPANT RE-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**:

**Name of Participant:**

Recently, your legal representative (relative, friend or an independent doctor where a relative or friend could not be contacted, acting on your behalf) consented you to take part in the MAPS-2 clinical trial. Your doctor or nurse has now deemed you to have regained the mental capacity to consent yourself into this clinical trial. If you wish to continue being in the MAPS-2 clinical trial, please read and sign the consent form below:

**Please initial box**

1. I, the above-named participant, confirm that I have read and understand the participant 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 withdraw from the study at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw 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 my medical records and data collected in the study may be/have been looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to me 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 my participation in this study. I understand that my 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 me or my named contact to provide information about my health status.

5. I agree to the information collected about me in this study will be used to support other research in the future and may be shared anonymously with other researchers.

6. I agree to my GP being informed of my participation in this study and will be asked to provide information on my status before I am contacted for the 6 month follow up.

7. I agree to you sending me a letter/email with a summary of the results. Yes/No

8. If I lose the capacity to make decisions for myself during the course of the study, I’d be happy to continue in the study unless my legal representative (relative, friend or independent doctor acting on my behalf) raises an objection to this.

9. I consent to take part in the above study.

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# Name of Participant Date Signature

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

Name of Person taking consent Date Signature

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

Name of Independent Witness  Date         Signature

(if necessary)

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

Role of Independent Witness

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