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

**CONSULTEE TELEPHONE DECLARATION FORM**

**(Final version 3.0 13/05/2022)**

**Study : Pharyngeal Electrical stimulation for Acute Stroke dysphagia Trial (PhEAST)**

**IRAS Project ID: 304658**

**Name of Researcher**:

**Name of Participant:**

**Please tick box once verbally agreed:**

1. I, the above-named consultee, have been consulted about the above-named participant’s participation in this research project. I confirm that I have read and understand the consultee information sheet version number xx dated xxx 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 I understand that I can request they are withdrawn from the study at any time, without giving any reason, and without their medical care or legal rights being affected.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 health status.

5. I agree to the information collected about my relative, being used to support other research in the future and be shared anonymously with other researchers.

6. I agree to my relative’s, 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 3 months, 6 months and 12 months follow up.

7. I agree to you sending my relative a letter/email with a summary of the study and possible follow on studies

YES / NO

8. I agree to signing a consultee form when I next attend the hospital.

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

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Name of Participant

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

Name of Consultee Relationship to Participant Signature

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

Name of Person taking declaration Date Signature

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

Name of Independent Witness Date Signature

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

Role of Independent Witness

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