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

**Legal Representative (Welfare Attorney (WA)/Welfare Guardian (WG)/Nearest Relative (NR))**

**TELEPHONE CONSENT FORM**

**(Final version 5.0: 07/03/2023)**

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

**IRAS Project ID: 306761**

**Name of Researcher**:

**Name of Participant:**

**Please tick box once verbally agreed:**

**Name of Legal Representative**

**(WA/WG/NR))**

1. I, the above-named Legal Representative (WA/WG/NR), 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 (WA/WG/NR) information sheet version number X 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 I understand that I can request they are withdrawn from the study at any time, without giving any reason, and without their medical care or legal rights being affected.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 the health status of my ward/relative. This includes their name, date of birth and CHI number.

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

6. I agree to my ward/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.

YES / NO

7. I agree to you sending my ward/relative a letter/email with a summary of the study.

8. I agree to signing a legal representative (WA/WG/NR) form when I next attend the hospital.

9. I consent to my ward/relative taking part in the above study.

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

Name of Participant

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

Name of legal representative Relationship to Participant

(WA/WG/NR)

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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 CRF and 1 for the medical notes