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

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

**CONSENT FORM**

**(Final version 1.0 24/06/2022)**

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

**IRAS Project ID: 306761**

**Name of Researcher**:

**Name of Participant:**

**Name of Informant (WA/WG/NR):**

1. I confirm that I have read and understood the information sheet version XXX dated XXX and have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw it at any time without giving any reason and without affecting my legal rights.

3. I agree that data collected during 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 my personal details will be kept confidential.

4. I agree that anonymised data that I have provided can be stored indefinitely for use in future relevant research by the Study team and other researchers.

5. I give permission for my personal information (including name, address, date of birth, telephone number and consent form) to be held on the database (University of Nottingham) for administration of the study.

6. I agree that the study team can contact me for follow-up questions relating to the participant for up to 12 months as detailed in the information sheet.

YES / NO

YES / NO

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

8. I agree to take part in the above study

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

Name of Participant

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

# Name of Informant Relationship Date Signature

# (WA/WG/NR) to Participant

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

Name of Person taking consent Role Date Signature

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