### *.*

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

**PARTICIPANT RECOVERED CAPACITY RE-CONSENT FORM**

**(Final version 4.0: 13/05/2022)**

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

**IRAS Project ID: 306761**

**Name of Researcher**:

**Name of Participant:**

Recently, your legal representative (Welfare Attorney/Welfare Guardian/Nearest Relative**)** gave their opinion on whether you would want to take part in the PhEAST 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 PhEAST 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 Recovered Capacity (Re-consent) 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 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 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 may 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 3 months, 6 months and 12 months 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 would be happy to continue in the study unless my legal representative (WA/WG/NR) raises an objection to this.

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

# 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 CRF and 1 for the medical notes