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

**Participant ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FORM**

**(Final version 3.0 date: 05/09/23)**

**Title of Study: Remote Conditioning After Stroke Trial 3 (RECAST-3)**

**IRAS Project ID: 277021 MHRA ref : *not applicable***

**Name of Researcher**:

**Name of Participant:**

**Please initial box**

1. I confirm that I have read and understand the Participant Information Sheet version number \_\_\_\_\_\_ dated \_\_\_\_\_\_ for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw 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 notes 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 my 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 in Scotland) and other central UK NHS bodies may be used to help contact me or provide information about my health status.

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

6. 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 consultee (friend or relative) raises

 an objection to this.

7. I agree to my GP being informed of my participation in this study, who will be asked to provide information on my status before I am contacted for the 90 Day follow up.

8. I agree to take part in the RECAST-3 study.

9. I agree to take part in the thrombectomy sub-study which includes an additional CT perfusion brain scan (selected hospitals only)

 N/A or initial box:

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

# Name of Participant Date Signature

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

Name of Person taking consent Date Signature

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

Name of Person **witnessing†/taking\*** verbal consent Date Signature

 (delete as appropriate)

**† e.g. Use if participant cannot write but does have capacity to consent**

**\* e.g. Use if time does not allow written urgent consent. Must be followed up by written consent as soon as is possible**