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

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

 **Welfare Attorney/Welfare Guardian/Nearest Relative Consent Form**

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

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

**IRAS Project ID: 282606** **MHRA ref: *not applicable***

**Name of Researcher**:

**Name of Welfare Attorney/Welfare Guardian/Nearest Relative:**

**Name of Participant:**

**Please initial box**

1. I the above named Welfare Attorney/Welfare Guardian/Nearest Relative have been consulted about the above named participant’s participation in this research project. I confirm that I have read and understand the WA/WG/NR information sheet version number \_\_\_\_ dated \_\_\_\_\_\_\_\_ for the above study and have had the opportunity to ask questions.

2. I understand that I can request he/she is withdrawn from the study at any time, without giving any reason, and without their medical care or legal rights being affected.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 their 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 my ward/relative/person I am consenting for or provide information about their health status.

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

6. I agree to you sending my ward/relative/person I am consenting for a letter/email with a summary of the study **Yes / No**

7. In my opinion he/she would have no objection to taking part in the RECAST-3 study.

8. In my opinion he/she would have no objection to taking part in the thrombectomy sub-study which includes an additional CT perfusion brain scan (selected hospitals only)

 N/A or initial box:

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

# Name of WA/WG/NR Date Signature

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

Name of Person taking consent Date Signature

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

Name of Person taking **verbal\*** consent Date Signature

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