### A drawing of a brain  Description automatically generated with medium confidence

**FULL CONSENT FORM FOR LEGAL REPRESENTATIVE - RELATIVE**

**(Final version 1.2: 16/01/2024)**

### Title of Study: TICH-3

**IRAS Project ID:** 297457  **EU CTR Number:  *2022-500587-35-01***

**Name of Researcher**:

**Name of Participant:**

**Please initial box**

1. I confirm that I have read and understand the information sheet final version 1.2 dated 16/01/2024 for the above study and have had the opportunity to ask questions.

2. I understand that my relative’s participation is voluntary and that they are free to withdraw at any time, without giving any reason, and without their medical care or legal rights being affected. I understand that should they/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 relative’s 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 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 participation in this study. I understand that my relative’s personal details will be kept confidential at my local Irish Hospital in line with GDPR and Article 35 of the EU Regulations 536/2014.

~~4~~. Consent for data use in possible future research (Optional) (delete yes/no and initial in box). YES / NO

 I agree that the information gathered about my relative can be stored by the
University of Nottingham, for possible use in future studies. I understand that some of
these studies may be carried out by researchers other than the current team who ran the
first study, including researchers working for commercial companies. Any data used will be
fully anonymised, and my relative/close friend will not be identifiable in anyway.

5. I agree to my relative’s family doctor being informed of their participation in this study and that they may be asked to provide information on their status for the 180 Day follow up.

6. I agree to you sending my relative a letter/email with a summary of the results YES/NO
(delete yes/no and initial in box).

7. I agree to my relative taking part in the above study.

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# Name of participant Relationship to participant

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

# Name of Relative Date Signature

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

Name of researcher taking consent Date Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes