

*Stroke Research Office  
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Centre: University Hospital of North Staffordshire  
Patient Identification Number for this study:.....

## RELATIVE CARER OR INDEPENDENT LEGAL REPRESENTATIVE CONSENT FORM

**Title of the project:** The Stroke Oxygen Study. A randomised controlled study of routine oxygen treatment after acute stroke

**Name of Principal investigator:** Dr C. Roffe

**Please initial box**

I confirm that I have read and understand the information sheet dated 2<sup>nd</sup> May 2008 (version 4) for the above study and have had the opportunity to consider the information, ask questions and have these answered satisfactorily.

I understand that his/her participation is voluntary and that he/she and I am free to withdraw consent at any time, without giving any reason, without his/her medical care or legal rights being affected.

I understand that sections of any of his/her medical notes may be looked at by responsible members of the research team or by members of the data monitoring committee. I give permission for these individuals to have access to his/her records.

I give permission for study staff to contact his/her general practitioner to find out their current address and how well they are, if they cannot contact them by letter after discharge from hospital.

I agree to \_\_\_\_\_ taking part in the above study.  
Name of the patient

\_\_\_\_\_  
Name of relative, carer or legal  
Representative (and relationship)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking consent  
(if different from researcher)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed 1 copy for the patient; 1 copy for the legal representative, 1 copy for or the research file, 1 (original) to be kept in the hospital notes