PLEASE FILE THE COMPLETED ORIGINAL IN THE SITE FILE AND TAKE 3 COPIES. GIVE 1 TO THE PATIENT, FILE 1 IN THE PATIENT MEDICAL NOTES AND KEEP 1 FOR PATIENT PACK.

Centre ID:0000

Trust logo to be inserted here

PATIENT CONSENT FORM (traditional format)
Version 3.1, 02.02.2016

Title of Project: Fluoxetine Or Control Under Supervision (FOCUS) - A randomised trial of fluoxetine or control to improve recovery after stroke

Please initial all boxes

1. I confirm that I have received the information sheet V3.1 dated 02.02.2016 for the FOCUS trial. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of any of my medical notes and data collected during the study, may be looked at by responsible individuals from University of Edinburgh, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I agree to my General Practitioner being informed of my taking part in the study. ☐

5. I agree to be contacted directly (or via close personal contacts, if I am unwell) at 1 month, 3 months, 6 months and 12 months after my stroke, so that the researchers can find out how I am getting on ☐

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6. I agree to information from my follow-up assessments being sent to my General Practitioner ☐

7. I understand that the information held and maintained by The Health and Social Care Information Centre and other central UK NHS bodies may be used to help contact me or provide information about my **long-term** health status. ☐

8 If I become less well and am no longer able to make decisions for myself, I would still like to complete the study and agree that information can be provided by a relative or carer ☐

9. I agree to take part in the study. ☐

_____	_____	_____
Name of Patient	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature
_____	_____	_____
*Name of Witness	Date	Signature

*If the patient has capacity but is unable to write then witnessed verbal consent may be obtained