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

CENTRE ID:0000

Trust logo to be inserted here

Consent form for patient's personal representative (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 relative's participation is voluntary and that my relative is free to withdraw at any time, without giving any reason, without medical care or legal rights being affected. ☐

3. I understand that relevant sections of any of my relatives' 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 relative taking part in this research. I give permission for these individuals to have access to the records. ☐

4. I agree to my relative's General Practitioner being informed about participation in the study. ☐

5. I agree to my relative and I being contacted directly at 1 month, 3 months, 6 months and 12 months after my relative's stroke, so that the researchers can find out how my relative is getting on. ☐

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6. I agree to information from my relative's follow-up assessments being sent to his/her 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 my relative or provide information about their **long-term** health status. ☐

8. I agree to my relative taking part in the study. ☐

_____
Name of Patient

_____	_____	_____
Name of patient representative	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature