ACT NoW Study aphasia friendly consent form

Office use only

Study number:

Version number (for staff use only):
AF_v4_18Dec2007

To be completed by person taking consent

Information provided to participant	**Provided to participant:** please tick
Cream Information Booklet (Standard)	
Standard Information on Audio tape	
Green Information Booklet (Moderate)	
Moderate Information on Audio tape	
Blue Information Booklet (Aphasia Friendly)	
Simplified Information on Audio tape	
Video/DVD	

Recruiter name: _____

Recruiter signature: _____

Please indicate **yes** or **no** to each of the statements below

I have been given **information** to keep about taking part in the **ACT NoW** study.

Yes

No

This information has been **explained** to me.

I have **understood** the information

Yes

No

I have been given the chance to ask **questions** about taking part in the study.

I am **happy** with the answers to my questions.

Yes

No

I understand that I can **stop** the study at any time.

I **do not** have to give a reason.

This will **not** affect the care I get from the NHS.

Yes

No

I allow the researchers to look at my **medical notes**.

Yes

No

I understand that my **doctor** will be informed that I am taking part in the ACT NoW study

Yes

No

I understand that a **video** will be made of me when my part in the study ends.

The video will only be seen by study staff.

Yes

No

I **agree** to **take part** in the ACT NoW study.

Yes

No

I have been given a copy of this form to **keep**.

Yes

No

Name of **person** taking consent | Date | Signature

_____ _____ _____

Name of **patient** | Date | Signature

_____ _____ _____

If patient is unable to sign:

Name of **witness** | Date | Signature of witness

_____ _____ _____

Relationship of witness to patient:_____