### 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: \_\_\_\_\_

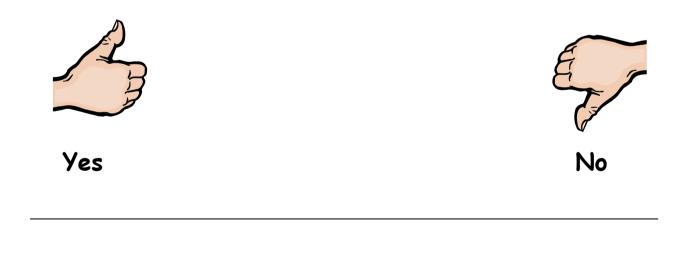
Please indicate yes or no to each of the statements below

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



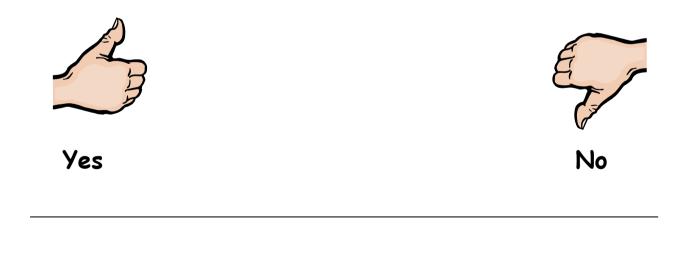
This information has been **explained** to me.

I have understood the information



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

I am happy with the answers to my questions.



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.



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

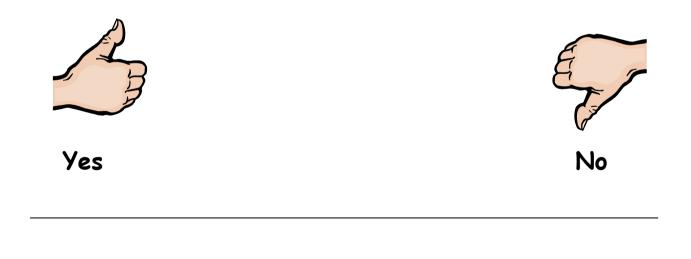


# I understand that my **doctor** will be informed that I am taking part in the ACT NoW study



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.



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



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



Name of <b>person</b> taking consent	Date	Signature
Name of <b>patient</b>	Date	Signature
		<u> </u>
If patient is unable to sign:		
Name of witness	Date	Signature of witness
Relationship of witness to patient:		