# Welfare Attorney/Welfare Guardian/Nearest Relative Consent Form

## Kinections Project

**Participant ID:**

*Contact Details for Person Taking Consent:*

_____

*Email:* *Mob. No.*

**Please initial box**

1. I confirm that I have read and understand the Participant Information Sheet (PIS)- Welfare Attorney/Welfare Guardian/Nearest Relative, Version no.1, date [24/01/2020] for the above study and have had the opportunity to consider the information and ask questions. ☐

2. I understand that my ward/relative/ person I am consenting for's participation is voluntary and that I am free to withdraw my ward/relative/person I am consenting for at any time, without giving any reason and without my ward's/relative/person I am consenting for's medical care or legal rights being affected. ☐

3. I understand that relevant sections of my ward/relative/person I am consenting for data collected during the study may be looked at by individuals from the Sponsor [University of the West of Scotland]. I give permission for these individuals to have access to the data. ☐

5. I agree to my ward's/relative/person I am consenting for's data being used for future ethically approved studies ☐

☐

6.. I agree to my ward/relative/person I am consenting for taking part in the above study ☐

I confirm that I am the Welfare Attorney or Welfare Guardian for

_____

_____ _____ _____

Name of person taking consent Date Signature

SAMPLE

I confirm that I am the Nearest Relative for _____.

Relationship to patient _____

_____ _____ _____

Name of person giving consent Date Signature

1x original – Researcher's Copy; 1x copy – to Person Giving Consent; 1x copy – Resident's care file

SAMPLE