**INVESTIGATOR SITE HEADED PAPER**

**Investigator: [Name]**

**CONSENT FORM FOR SUBJECTS UNABLE TO GIVE CONSENT THEMSELVES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Study ID #** |  | **Site #** |  |
| **Name of Research Doctor** |  | | |

Regarding patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form should be completed by a consultant doctor who is unconnected with the research study only in situations where the patient is temporarily unable to provide informed consent for themselves and if there is no relative / friend / partner willing and capable to act as the personal legal representative. The consultant primarily responsible for the medical treatment of the patient or a person nominated by the relevant health care provider, can act as a professional legal representative for the patient, providing that they are not connected with the conduct of this study.

I, Dr / Mr / Ms / Prof\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, declare by signing this form that I have read the Patient Information Sheet version \_\_\_\_\_, dated \_\_\_\_\_\_\_ and have no objection for this patient to be entered into this research study. I also understand that should the patient regain consciousness they will be fully informed of the decision to enter them into this research study and consent will be sought from them for their continued participation. I agree that the patient’s consent will override my consent when the patient is able to give consent.

|  |  |
| --- | --- |
| Name of Professional Legal Representative | Person responsible for collecting the informed consent |
| *Date:*  *Signature:*  *Printed Name:* | *Date:*  *Signature:*  *Printed Name:* |