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A Randomised Controlled Trial comparing Dynamic Temporal and Tactile Cueing with Usual Care for Childhood Apraxia of Speech

PARENT/CARER CONSENT FORM

I, ... [PRINT PARENT'S/CARER'S NAME], consent to my child

..... [PRINT CHILD'S NAME] participating in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what my child will be asked to do, and any risks/benefits involved.
- I have read the Information Statement and have been able to discuss my child's involvement in the study with the researchers if I wished to do so.
- I understand that being in this study is completely voluntary and my child does not have to take part. My decision whether to let them take part in the study will not affect our relationship with the researchers or anyone else at The University of Sydney, Curtin University, James Cook University, Murdoch Children's Research Institute (MCRI), South-Western Sydney Local Health District Speech Pathology department, Sydney Children's Hospital, Randwick, Syracuse University, the University of Canberra, or the University of Canterbury now or in the future.
- I understand that the Chief Investigators may use my child's data (including assessment, treatment videos and audio examples) for teaching and instructional purposes.
- I understand that there is a small risk of my child becoming tired or frustrated during the study. I understand that the researchers and research speech pathologists are experienced speech pathologists and are used to managing such situations. I am aware that if my child becomes tired or frustrated, he/she will be offered a rest break.
- I understand that my child can withdraw from the study at any time.

- I understand with my withdrawal from the study, I will be asked if I would prefer for all audio and video recordings to be erased and the information provided excluded from the study or whether I am happy for the data already collected, to be used in the study.

- I understand that personal information about my child that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about my child will only be told to others with my permission, except as required by law.

- I understand I will be asked to consider my child's limited and deidentified data being shared on Phonbank at the end of our participation in the study:
  - ❑ I AM interested in learning more about Phonbank
  - ❑ I am NOT interested in Phonbank at this time

- I understand that the results of this study may be published, and that publications will not contain my child's name or any identifiable information about my child.

- I understand that I may be required to wear protective equipment (for example, a face mask) throughout the duration of all of my child's assessment and treatment sessions. I also understand that if there are further community outbreaks of COVID-19 and local health authorities recommend increasing the use of protective equipment, I will wear the recommended amount of protective equipment during my child's treatment sessions.

- I consent to:

  a. *Audio and video recording* YES □ NO □

  I understand that these recordings will be used for data collection and analysis purposes, and that they will be viewed by the researchers of the study.

  I also understand that the Chief Investigators may use this data for teaching and instructional purposes.

  If you are unwilling for your child to be both audio and video recorded, we thank you for your time but will not be able to include you in this study.

  b. *The researchers contacting my child's current treating Speech Pathologist*
  YES □ NO □

  While your child is receiving 'Usual Care', you consent to us contacting your treating Speech Pathologist to collect data about the therapy the clinician is using with your child, treatment goals, therapy progress and minutes of therapy per week your child has attended.

If you answered YES to "c*. The researchers contacting my child's current treating Speech Pathologist*", please provide the details for your child's treating speech pathologist.

Speech Pathologist Name:	
Speech Pathologist Email Address:	

c. *Being contacted for other projects* YES □ NO □

d. *Receiving feedback at the end of the study* YES □ NO □

If you answered YES to "e. *Receiving feedback*", please provide your details i.e. postal address or email address.

Contact details:

_____

_____

Parent's/carer's signature:	**Researcher's signature:**
.....	.....
Signature	**Signature**
.....	.....
PRINT name	**PRINT name**
.....	.....
Date	**Date**