

Informed Consent Form for Biomedical Research Involving Human Subjects

We sincerely invite you to participate in a research study. This informed consent form provides you with information to help you decide whether to participate in this study. Please read it carefully, and if you have any questions, feel free to consult the researcher in charge of this study.

Project Title:

Study on the Effects of Remimazolam and Dexmedetomidine on Emotional and Cognitive Functions in Patients with Ischemic Stroke

Department Responsible for Study:

Department of Anesthesiology

Principal Investigator:

Nan Chen

Version Number (Mandatory):

20250618

Dear Participant,

We sincerely hope you can participate in this study. This study follows the principles outlined in the Declaration of Helsinki, adheres to medical ethics regulations, and has been approved by the Ethics Committee of Xinjiang Uygur Autonomous Region People's Hospital. Participation in this study is entirely voluntary, and you have the right to withdraw at any stage without it affecting your future medical examinations or treatment.

1. Purpose of the Study:

(Include details about the purpose of the study here.)

2. Study Procedures:

(Include details about the procedures and what participants will need to do.)

3. Risks and Discomforts:

(Include details about potential risks or discomforts associated with participating in this study.)

4. Benefits:

(Include details about any potential direct or indirect benefits to the participant from being a part of the study.)

5. Costs and Compensation:

(Provide clear information about who will cover costs incurred during the study and whether compensation will be provided in case of injury or adverse events.)

6. Alternative Therapies:

For studies involving interventional treatments, describe alternative therapies or treatments available. If no interventional treatment is involved, clarify this information.

7. Confidentiality:

If you decide to participate in this study, your participation and all personal data will remain confidential. Your blood samples will be labeled with a study code number instead of your name. Your identity will not be disclosed, and identifiable personal information will not be shared with individuals outside the research team unless you grant explicit permission.

All members of the research team are required to keep your identity strictly confidential. The responsible physician and other research personnel will use your medical information for research purposes. This information may include your name, address, phone number, medical history, and the data obtained during your study visits.

Your files will be stored in locked cabinets and accessed only by the research team. To ensure the study is conducted in accordance with regulations, governmental regulatory departments or members of the ethics committee may review your personal data when necessary.

When the study results are published, no personal information about you will be disclosed.

You have the option to decline participation in this study or to notify the researcher at any time if you wish to withdraw. Your data will not be included in the research results, and your medical care and rights will not be affected in any way.

If you require alternative treatment, fail to comply with the study protocol, experience study - related injury, or for any other reason, the research physician reserves the right to terminate your participation in the study.

8. Contacts:

If you have any questions about the design, process, or results of this study, or if you wish to get in touch with us, please feel free to contact us at **0991 - 8568013**. We will do our best to address your concerns. Thank you for your trust and support! If you belong to an ethnic minority group, a physician fluent in your native language will be available to address your questions.

Participant Declaration

I (or a direct family member) have understood the purpose, content, significance, and risks of this study. I voluntarily agree to participate in this research study.

Signatures

Participant Signature:

_____ Year ___ Month ___ Day Contact Phone Number: _____

Participant's Direct Family Member Signature:

_____ Year ___ Month ___ Day Contact Phone Number: _____

Authorized Representative Signature:

_____ Year ___ Month ___ Day Contact Phone Number: _____

Physician (Researcher) Signature:

_____ Year ___ Month ___ Day Contact Phone Number: _____

Translator/Interpreter Signature (if applicable):

_____ Year ___ Month ___ Day Contact Phone Number: _____

(For study participants from ethnic minority groups, this field should include approved management documentation.)

If you need further adjustments or wish to modify specific components of this translation, please let me know!