Study Number: REC 09/H1210/88

Study Title **'CLUSTER RANDOMISED CONTROLLED TRIAL OF AN OCCUPATIONAL THERAPY INTERVENTION FOR RESIDENTS WITH STROKE IN UK CARE-HOMES (ACRONYM-OTCH).'**

Dear «PM_Title» «PM_surname»

«PracticeName» has previously been notified of patient/s involved in the above research trial. The patient/s have consented to take part in the trial and agreed you should be notified of such. Copy of signed consent form/s enclosed.

We would be grateful if you would verify their eligibility for the trial by completing the enclosed GP Confirmation Form to confirm diagnosis of stroke or TIA. Please complete for all patients listed even if they have moved away from your practice or have passed away. Alternatively please contact us to arrange a convenient time to gather the information over the telephone. In addition it would also be appreciated if you were to provide us with a copy of their current prescription medication for completeness of our records. This information will be anonymised upon receipt; however, should you wish to oversee this, please write the appropriate Participant ID (to be found on the GP confirmation form and Consent Form) on the corresponding medication list.

We enclose a freepost envelope for the return of the completed GP Confirmation Form and prescription medication details and would very much appreciate their return by (insert required date)

Should you have any queries please do not hesitate to contact a member of the team otherwise we look forward to hearing from you in due course.

Yours sincerely,

OTCH Trial Manager

GP practice diagnosis form returned to the research team

GP CONFIRMATION FORM – «PracticeName»

RETURN COMPLETED FORM TO THE OTCH STUDY TEAM IN THE REPLY PAID ENVELOPE SUPPLIED

COMPLETED BY:

Name.....

Position.....

Date.....

PLEASE COMPLETE AND RETURN FOR ALL PATIENTS LISTED REGARDLESS OF WHETHER THEY HAVE SUBSEQUENTLY LEFT THE PRACTICE OR PASSED AWAY. RETURN COMPLETED FORM TO THE OTCH STUDY TEAM IN THE REPLY PAID ENVELOPE SUPPLIED

Participant ID	Care Home	Patient on QOF Stroke 1 Register? (✓)	If no, what evidence of stroke or TIA is detailed in medical history (please complete)	Copy current prescription enclosed (✓)
«ID»	«HomeName»			
«ID»	«HomeName»			
«ID»	«HomeName»			