Date: 25/01/2022

Official Title: The Effect of Different Neuromodulation Techniques in the Treatment of Multiple Sclerosis Patients With Neurogenic Bladder Dysfunction

INFORMED CONSENT FORM

Below is detailed information about this research, please read it all carefully.

WHAT IS OUR WORK?

This study examines the comparison of the effectiveness of posterior tibial nerve stimulation and repetitive transcranial magnetic stimulation methods in Multiple Sclerosis patients.

WHAT IS THE PURPOSE OF THE WORK?

It was aimed to compare the effects of posterior tibial nerve stimulation and repetitive transcranial magnetic stimulation methods on urological parameters in the treatment of neurogenic bladder due to the diagnosis of Multiple Sclerosis in women aged 18-65 years.

HOW TO MAKE AN APPLICATION?

Repetitive transcranial magnetic stimulation will be applied with a coil placed on the scalp that creates magnetic pulses of approximately 1.5-2.0 tesla for a very short time (100-300 ms.), accompanied by a doctor and physiotherapist. Tibial tibial nerve stimulation will be performed by the physiotherapist with an electrode placed on the inner surface of the ankle and an electrotherapy device that gives an adjusted electrical stimulation. In the evaluation; It was planned to use extended disability status scale (EDSS), overactive bladder assessment form (OAB-V8), incontinence severity index (ISI), incontinence quality of life scale (I-QOL), voiding diary and urodynamics. Individuals will be evaluated by a physiotherapist and doctor. The anticipated application time of these tests is 30-45 minutes.

The tests to be applied do not have any negative side effects and will be done without tiring you.

WHAT ARE MY RESPONSIBILITIES?

Patients included in our study are expected to comply with treatment and assessments. In cases where these conditions are not complied with, the investigator has the authority to exclude you from the program.

EXPERIMENTAL SECTIONS OF THE RESEARCH

Our research is not an experimental study.

WHAT ARE THE EXPECTED POSSIBLE RISKS OR DISORDERS WITH PARTICIPATION IN THE STUDY?

The treatment and evaluation approaches to be applied in this study do not carry any risk and there is no effect that will disturb you. In addition, in cases where the expected benefit is not obtained, you will be given the necessary explanation about the reasons for this.

PARTICIPANTS' INVOLVEMENT

You will participate in the study voluntarily, or you may refuse to participate in the study and leave the study voluntarily without any sanction.

CONTACT

The contact and phone number of the patient or legal representatives in case of any problems with the research or the research are given below:

Pt.Pınar Atak Çakır 05360569404

DURATION OF THE STUDY: Our study will continue until your treatment sessions are completed.

CAN THE CONFIDENTIALITY BE PROVIDED ABOUT MY INFORMATION?

All your medical and identity information will be kept confidential and your identity information will not be given even if the research is published, however, the ethical committees and official authorities in charge of the research can access your medical information when necessary. You can also access your own medical information whenever you want.

Consent to Participate in the Study

I have read all the explanations in the "Informed Consent Form". Written and verbal explanation about the research whose subject and purpose is stated above was given to me by the physician/physiotherapist whose name is mentioned below. I asked all the questions that came to my mind to the researcher, I have understood in detail all the written and verbal explanations made to me. I know that I have voluntarily participated in the research and that I can leave the research at any time with or without justification. I agree to participate in this research voluntarily, without any pressure or coercion.

I have been given a signed and dated copy of this form.

VOLUNTEER		**SIGNATURE**
NAME & SURNAME		
ADDRESS		
PHONE		
DATE		

THE RESEARCHER MAKING THE EXPLANATIONS		**SIGNATURE**
NAME & SURNAME		
DATE		

LEGAL REPRESENTATIVE OF THE PATIENT (IF NECESSARY)		SIGANTURE
NAME & SURNAME		
THE DEGREE OF PROXIMITY		
DATE		

OF THE PERSON WITNESSING THE PROCESS OF GIVING CONSENT FROM BEGINNING TO END (IF ANY)		SIGNATURE
NAME & SURNAME		
DATE		