

Official Title: Vibration Impact on Parkinson's Tremor

NCT #: NCT03799614

Date: 10/1/2018

## RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

**STUDY TITLE:** Vibration Impact on Tremor

**VCU INVESTIGATOR:** Ingrid Pretzer-Aboff

**SPONSOR: Resonate Forward, LLC**

The Principal Investigator is a founder, a member of the Board of Directors, and has an ownership interest in Resonate Forward, LLC, which is the sponsor of this study.

*NOTE: In this consent form, “you” always refers to the research participant.*

### ABOUT THIS CONSENT FORM

You are being invited to participate in a research study. **It is important that you carefully think about whether being in this study is right for you and your situation.**

This consent form is meant to assist you in thinking about whether or not you want to be in this study. **Please ask the study doctor or the study staff to explain any information in this consent document that is not clear to you.** You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

Your participation is voluntary. You may decide to not participate in this study. If you do participate, you may withdraw from the study at any time. Your decision not to take part or to withdraw will involve no penalty or loss of benefits to which you are otherwise entitled.

### AN OVERVIEW OF THE STUDY AND KEY INFORMATION

The purpose of this research study is to test the safety, tolerability, and the effect of vibration (delivered by an experimental device called RMBand) on parkinsonian tremor. The RMBand was developed by Resonate Forward, LLC (RF). This RMBand was designed to administer a vibration to the wearer to decrease or stop tremor in persons with Parkinson's disease (PD) while wearing the device. We hypothesize that the RMBand will be safe, comfortable to wear, easy to apply, will decrease your tremor, and that the effects of vibration on tremor will be obvious and related to the dose of vibration. You are being asked to participate in this study because you have been diagnosed with Parkinson's disease with a tremor and may meet the study entry requirements.

People with Parkinson's disease often experience tremor that can interfere with the person's ability to conduct daily activities. Drug treatments can help but over time, some people experience an increasingly shorter period of symptom relief. Researchers have found that vibration therapy can help improve tremor symptoms. This study will test the RMBand, a light-weight, portable device that delivers vibration to the arm. The localized vibration therapy has the potential to decrease tremors. The RMBand is an investigational device which means it has not been approved by the U. S. Food and Drug Administration (FDA).

## PROCEDURES

The study visit will take place at the PMDC@NOW building.

PMDC@NOW (Neuroscience, Orthopedics, and Wellness Center)  
11958 W. Broad Street  
Henrico, VA 23233

During the visit you will:

1. visit a single time for the study
2. have the vibration device (RMBand) placed on the bicep of the arm that is most affected by tremor
3. have a device placed on each wrist to measure the amount of tremor you are experiencing in each arm
4. be randomized to receive either a low dose frequency (80Hz) or higher dose frequency (160Hz) of vibration therapy. *Note:* Randomization means that you are put into a group by chance. A computer program will place you in one of the study groups. Neither you nor your study doctor can choose the group you will be in. You will have an equal chance of being placed in either group.
5. complete a brief survey
6. have a brief neurological exam performed before, during, and after vibration therapy has been applied
7. be videotaped to record your tremors before, during and after vibration therapy
8. answer questions about your medical history
9. answer questions about the vibration therapy.

Your participation in this study will last up to 2 hours. Approximately 38 people will participate in this study.

If you decide not to enter this study, you can receive the usual care that you would receive even if you were not in the study. This includes the medications used to treat your Parkinson's tremor such as levodopa (dopamine replacement), dopamine agonists (class of drugs that activate your brain to produce dopamine), and anticholinergics (class of drug used to treat tremor). The study doctor will discuss these options with you. You do not have to participate in this study to be treated for tremors related to Parkinson's disease.

In general, we will not give you any individual results from the study. If we find something of medical importance to you, we will inform you, although we expect that this will be a very rare occurrence.

**Please read, or have someone read to you, the rest of this document. If there is anything you don't understand, be sure to ask the study staff.**

### **WHAT ARE THE BENEFITS FROM BEING IN THE STUDY?**

There is some evidence that vibration therapy is effective in reducing tremors. However, it is unlikely that it will work with everyone, and we cannot promise that it will help you. This study may help the study team learn things that may help other people in the future.

### **WHAT RISKS AND DISCOMFORTS COULD I EXPERIENCE FROM BEING IN THE STUDY?**

Your condition may not get better or may become worse while you are in this study.

#### **Possible Risks and Discomforts**

Rare (Less than a 1% chance that this will happen)

- If you have a deep brain stimulator, there is a chance that the RMBand may turn it off. As a result, you may feel a brief increase in your Parkinson's symptoms. If that occurs the study doctor will be there to return it to normal working status for you.

Occasional (Between 1-10% chance that this will happen)

- You may feel some discomfort such as a tingling sensation from the vibration and/or discomfort from the straps that the device is attached. We will adjust the device to your comfort level.
- Completing the surveys and assessments may be somewhat tiring for you. You can take breaks at any time.

#### **Non-Physical Risks**

Participation in research might involve some loss of privacy. There is a small risk that someone outside the research study could see and misuse information about you.

#### **Unknown or Unforeseeable Risks**

The researchers will let you know about any significant new findings (such as additional risks or discomforts) that might make you change your mind about participating in the study.

The RMBand involves risks that are currently unknown or unforeseeable.

### **WHAT ARE THE COSTS?**

The vibration device will be provided by the sponsor at no cost to you. You will not be charged for any study visits, tests, or procedures.

### **WILL I BE PAID TO PARTICIPATE IN THE STUDY?**

You will not be paid for your participation in this study.

Please be aware that the investigative team and the University may receive money for the conduct of this study.

### **WHAT HAPPENS IF I AM INJURED OR BECOME SICK BECAUSE I TOOK PART IN THE STUDY?**

If you are injured by, or become ill, from participating in this study, please contact your study doctor immediately. Medical treatment is available at the Virginia Commonwealth University Health System (VCU Health System). Your study doctor will arrange for short-term emergency care at the VCU Health System or for a referral if it is needed.

Fees for such treatment may be billed to you or to appropriate third-party insurance. Your health insurance company may or may not pay for treatment of injuries or illness as a result of your participation in this study. To help avoid research-related injury or illness, it is very important to follow all study directions.

### **CAN I STOP BEING IN THE STUDY?**

You can stop being in this research study at any time. Leaving the study will not affect your medical care, employment status, or academic standing at VCU or VCU Health. Tell the study staff if you are thinking about stopping or decide to stop.

Your participation in this study may be stopped at any time by the study doctor without your consent. The reasons might include:

- the study doctor thinks it necessary for your health or safety
- you are not eligible for the study
- the sponsor has stopped the study
- you have not followed study instructions
- administrative reasons require your withdrawal

### **HOW WILL INFORMATION ABOUT ME BE PROTECTED?**

VCU and the VCU Health System have established secure research databases and computer systems to store information and to help with monitoring and oversight of research. Your information may be kept in these databases but are only accessible to individuals working on this study or authorized individuals who have access for specific research related tasks.

Identifiable information in these databases are not released outside VCU unless stated in this consent or required by law. Although results of this research may be presented at meetings or in publications, identifiable personal information about participants will not be disclosed.

Personal information about you might be shared with or copied by authorized representatives from the following organizations for the purposes of managing, monitoring and overseeing this study:

- The study Sponsor, representatives of the sponsor and other collaborating organizations
- Representatives of VCU and the VCU Health System
- Officials of the Department of Health and Human Services or the Federal Food and Drug Administration

A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Website will include a summary of the results. You can search this Web site at anytime.

**Future Research Studies**

In the future, identifiers might be removed from the information and samples you provide in this study, and after that removal, the information/samples could be used for other research studies by this study team without asking you for additional consent.

**HOW WILL MY HEALTH INFORMATION BE USED AND SHARED DURING THIS STUDY?**

As part of this research study, we will ask you to share identifiable health information with us and/or permit us to access existing information from your healthcare records. New health information may also be created from study-related tests, procedures, visits, and/or questionnaires. This type of information is considered “Protected Health Information” that is protected by federal law.

**What type of health information will be used or shared with others during this research?**

The following types of information may be used for the conduct of this research:

- History and physical exam
- Photographs, videotapes

**Who will use or share protected health information about me?**

VCU and VCU Health are required by law to protect your identifiable health information. By consenting to this study, you authorize VCU/VCU Health to use and/or share your health information for this research. The health information listed above may be used by and/or shared with the following people and groups to conduct, monitor, and oversee the research:

- Principal Investigator and Research Staff
- Institutional Review Boards
- Research Collaborators
- Others as Required by Law
- Study Sponsor
- Data Safety Monitoring Boards
- Government/Health Agencies

Once your health information has been disclosed to anyone outside of this study, the information may no longer be protected under this authorization.

**When will this authorization (permission) to use my protected health information expire?**

This authorization will expire when the research study is closed, or there is no need to review, analyze and consider the data generated by the research project, whichever is later.

**Statement of Privacy Rights**

You may change your mind and revoke (take back) the right to use your protected health information at any time. However, even if you revoke this authorization, the researchers may still use or disclose health information they have already collected about you for this study. If you revoke this Authorization you may no longer be allowed to participate in the research study. To revoke this Authorization, you must write to the Principal Investigator.

**WHO SHOULD I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY?**

If you have any questions, complaints, or concerns about your participation in this research, contact:

Ingrid Pretzer-Aboff, PhD, RN, FGSA  
Adult Health and Nursing Systems  
1100 E. Leigh St.  
Richmond, VA 23298  
804-828-3340

Leslie Cloud, MD, MSc  
Parkinson's Movement & Disorders Center  
11958 W. Broad St  
Henrico, VA 23233  
804-356-7521

The researchers named above are the best persons to call for questions about your participation in this study.

If you have general questions about your rights as a participant in this or any other research, you may contact:

Virginia Commonwealth University Office of Research  
800 East Leigh Street, Suite 3000  
Box 980568  
Richmond, VA 23298  
Telephone: (804) 827-2157

Contact this number to ask general questions, to obtain information or offer input, and to express concerns or complaints about research. You may also call this number if you cannot reach the research team or if you wish to talk to someone else. General information about participation in research studies can also be found at <http://www.research.vcu.edu/irb/volunteers.htm>.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

**STATEMENT OF CONSENT**

I have been provided with an opportunity to read this consent form carefully. All of the questions that I wish to raise concerning this study have been answered. By signing this consent form, I have not waived any of the legal rights or benefits to which I otherwise would be entitled. My signature indicates that I freely consent to participate in this research study. I will receive a copy of the consent form for my records.

May we (the research team) use videos of you from this study in research conferences, while teaching students, and in other presentations? Please initial response.

\_\_\_\_\_ YES      \_\_\_\_\_ only if you hide my face      \_\_\_\_\_ NO

May we (the research team) use photos of you from this study in research conferences, while teaching students, and in other presentations? Please initial response.

\_\_\_\_\_ YES      \_\_\_\_\_ only if you hide my face      \_\_\_\_\_ NO

\_\_\_\_\_  
Adult Participant Name (Printed)

\_\_\_\_\_  
Adult Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Person Conducting Consent Discussion (Printed)

\_\_\_\_\_  
Signature of Person Conducting Consent Discussion

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal Investigator Signature (if different from above)

\_\_\_\_\_  
Date