

TNO:	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>		<h2 style="margin: 0;">Screening and Eligibility Form</h2>
Site:			

THIS CRF SHOULD BE COMPLETED FOR ALL PATIENTS ADMITTED TO ICU WITH TRAUMATIC BRAIN INJURY WHERE AN ICP BOLT HAS BEEN INSERTED

INCLUSION CRITERIA		
<i>Participants will be excluded if ANY of the following are No:</i>	YES	NO
Adult aged 16 years or above	<input type="checkbox"/>	<input type="checkbox"/>
Admission to ICU following traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>
ICP > 20mmHg for more than 5 minutes despite stage 1 procedures	<input type="checkbox"/>	<input type="checkbox"/>
< 10 days from initial primary head injury	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal CT scan consistent with TBI	<input type="checkbox"/>	<input type="checkbox"/>
EXCLUSION CRITERIA		
<i>Participants will be excluded if ANY of the following are Yes:</i>	YES	NO
Devastating brain injury with withdrawal of treatment anticipated in the next 24 hours	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Severe hypernatraemia (serum sodium > 155 mmol/L)	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Patient enrolled in the SOS trial?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, record the name of the medically qualified doctor who has confirmed the patient is eligible to be enrolled in the SOS trial, and the date and time confirmed. This should also be reflected in the medical notes.

Has a medically qualified doctor assessed and confirmed that the patient is eligible?	<div style="text-align: right;"> Yes <input type="checkbox"/> No <input type="checkbox"/> </div>
Name and signature of doctor	
Date and time confirmed	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> DD/MMM/YYYY HH:MM </div>

If the patient is not enrolled, please give the reason for non-enrolment (tick the primary reason only):

REASON FOR NON-ENROLMENT	
Eligible but consent declined by personal legal representative	<input type="checkbox"/>
Eligible but consent declined by professional legal representative	<input type="checkbox"/>
Not eligible	<input type="checkbox"/>
Patient already received hyperosmolar therapy while on intensive care unit	<input type="checkbox"/>
No one with delegated responsibility (on delegation log) available to enrol patient	<input type="checkbox"/>
Logistical e.g. no mannitol/hypertonic saline available	<input type="checkbox"/>
Trial on hold	<input type="checkbox"/>
Already enrolled in CTIMP, specify _____	<input type="checkbox"/>
Forgot/missed	<input type="checkbox"/>
Other, specify _____	<input type="checkbox"/>