IRAS ID: 260350

(Form to be on headed paper)

SOS trial: Hyperosmolar therapy in traumatic brain injury

CONSENT FORM FOR PATIENT (POST-ENROLMENT)

Participant Identification Number for this trial:

Please **initial** box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my continued participation in this trial is voluntary and that I can request to be withdrawn at any time without giving any reason and without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from University of Warwick, regulatory authorities or from the NHS Trust, where it is relevant to me taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

5. I agree to my General Practitioner and people who are caring for me being informed about my participation in the study, and any necessary exchange of information about me between my GP, people who are caring for me and the research team. ☐

6. I understand that the information held and maintained by NHS organisations, NHS England, Intensive Care National Audit and Research, and Patient Episodes Data for Wales (if applicable), Information Services Division Scotland (if applicable) and Health and Social Care Northern Ireland (if applicable) may be used to help contact me and provide information about my health status. I give permission for my name, NHS number, date of birth and address to be sent to these organisations in order to obtain this information. ☐

7. I agree for my contact details including address, email address and telephone number to be used by the research team at University of Warwick to contact me in relation to the study. I understand the University of Warwick will use my phone number to send me text messages via a text messaging service. ☐

8. I give my consent to continue to take part in the above study. ☐

Name of Patient	**Signature**	**Date (dd/mm/yy)**
Name of Person Taking Consent	**Signature**	**Date (dd/mm/yy)**

This project is funded by the National Institute for Health and Care Research (NIHR) Health Technology Assessment (HTA) programme (Ref: 17/120/01)

If witnessed verbal consent has been obtained from the patient:

I witnessed the accurate reading of the consent form to the patient, who was able to ask any questions and got satisfactory replies.

I confirm that they gave their consent freely.

Name of Patient		
Name of Witness	**Signature**	**Date (dd/mm/yy)**
Name of Person Taking Consent	**Signature**	**Date (dd/mm/yy)**

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