



# SOS trial: Hyperosmolar therapy in traumatic brain injury

## CONSENT FORM FOR PERSONAL LEGAL REPRESENTATIVE (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 I understand that my relative's participation in this trial is voluntary and that I can request that he/she is withdrawn at any time without giving any reason and without their medical care or legal rights being affected.
- 3. I understand that relevant sections of my relative's 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 my relative taking part in this research. I give permission for these individuals to have access to my relative's records.
- 4. I understand that the information collected about my relative will be used to support other research in the future, and may be shared anonymously with other researchers.
- 5. I agree to my relative's General Practitioner and people who are caring for them being informed about their participation in the study and any necessary exchange of information about my relative between their GP, people who are caring for them and the research team.
- 6. I understand that the information held and maintained by NHS organisations, NHS England, Intensive Care National Audit and Research, 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/my relative and provide information about his/her health status. I give permission for my relative's 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/my relative's contact details, including address, email address and telephone number to be used by the research team at University of Warwick to contact me/my relative in relation to the study. I understand the University of Warwick will use my/my relative's phone number to send me/my relative text messages via a text messaging service.
- 8. I give consent, on behalf of my relative, for them to continue in the above study.

\_\_\_\_\_  
Name of Legal Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (dd/mm/yy)

*Relationship to participant:.....*

\_\_\_\_\_  
Name of Person Taking Consent

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (dd/mm/yy)



**If verbal consent has been obtained over the telephone because the personal legal representative is not able to be present physically to sign for themselves:**

I witnessed the accurate reading of the consent form to the participant's personal legal representative, who was able to ask any questions and got satisfactory replies.

I confirm that they gave their consent freely.

\_\_\_\_\_  
Name of Legal Representative

\_\_\_\_\_  
Relationship to participant

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (dd/mm/yy)

\_\_\_\_\_  
Name of Person Taking Consent

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (dd/mm/yy)