IRAS ID: 260350

(Form to be on headed paper)

SOS trial: Hyperosmolar therapy in traumatic brain injury

CONSENT FORM FOR PROF. LEGAL REPRESENTATIVE (PRE-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 I understand that the patient's participation in this trial is voluntary and that I can request that he/she is withdrawn at any time without giving any reason and without their medical care or legal rights being affected.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 the patient'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 them taking part in this research. I give permission for these individuals to have access to the patient's records. ☐

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

5. I agree to the patient'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 the patient 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 the patient and provide information about his/her health status. I give permission for the patient'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/the patient's contact details, including address, email address and telephone number to be used by the research team at University of Warwick to contact me/the patient in relation to the study. I understand the University of Warwick will use my/the patient's phone number to send me/the patient text messages via a text messaging service. ☐

8. I give consent, on behalf of the patient, for them to take part 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)**

When completed: original for researcher site file; 1 copy for legal representative; 1 copy to be kept in medical notes.
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