Surgical Trial in Traumatic Intracerebral Haemorrhage: STITCH (Trauma)

CONSULTEE FORM

Patient Name:

Please tick as appropriate

I believe that my relative (named above) would wish to participate in the above clinical study, the nature of which has been explained by: ☐

Name of Consultant/Doctor

I have read and understand the Information Sheet dated __/__/____(version _) for the above study. I have had the opportunity to consider the information and any questions I had relating to the study have been answered to my satisfaction. ☐

In my opinion he/she would have no objection to taking part in the above study. ☐

I understand that I can request that he/she is withdrawn from the study at any time, without giving a reason and without his/her care or legal rights being affected. ☐

I confirm that I am not aware that my relative has made any advance directive with regard to their care. ☐

In my opinion my relative would not object to their General Practitioner being informed that they are participating in the study. ☐

I understand that any personal information collected about my relative for the trial will be treated as strictly confidential, and that their medical records will be consulted and data from the study will be published anonymously by the funder and the researchers involved in medical journals and at research meetings. ☐

I understand that relevant sections of my relative's medical notes and data collected during the study, may be looked at by individuals from Newcastle University, from regulatory authorities or from the NHS Trust, where it is relevant to my relative's taking part in this research. In my opinion my relative would not object for these individuals to have access to their medical records. ☐

Signature of relative:

Name of relative:

Witnessed by: (e.g., Senior Nurse)

Position:

Date: