PLINTH
PLATFORM STUDY FOR INTRACEREBRAL HAEMORRHAGE

CHIEF SCIENTIST OFFICE

THE UNIVERSITY of EDINBURGH

NHS Lothian

STUDY ID: _ _ _ _ _ _

Welfare Attorney/Welfare Guardian/Nearest Relative Consent Form

IRAS reference number: 325272 **REC number**: 23-SS-0087

Initial boxes to indicate your agreement with the compulsory parts of the study:

1.	I have received the Short Welfare Attorney / Welfare Guardian / Nearest Relative Information Leaflet version 3.0 (dated 4th June 2024) for the PLINTH feasibility study and the Tailored Talks presentation version 3.0 and/or the supplementary patient information leaflet version 4.0 (dated 4th June 2024). I have had the opportunity to consider the information provided. I have had the opportunity to ask questions and I have had these answered satisfactorily.	*Initial here*
2.	I understand that the person I am consenting for's participation in the PLINTH feasibility study is voluntary and that they are free to withdraw at any time, without giving any reason and without their medical care or legal rights being affected.	*Initial here*
3.	I understand that relevant sections of the person I am consenting for's medical notes and data collected during the study may be looked at by individuals from the regulatory authorities, from the study Sponsor (NHS Lothian and the University of Edinburgh), or from other NHS Boards where it is relevant to their taking part in this research. I give permission for those individuals to have access to their records.	*Initial here*
4.	I give permission for the person I am consenting for's Community Health Index (CHI) or NHS number, and hospital number to be collected and passed to the University of Edinburgh.	*Initial here*
5.	I give permission for the person I am consenting for's personal information (including name, address, date of birth, telephone number and consent form) to be passed to the University of Edinburgh and Study Coordinating Centre for study administration of the study.	*Initial here*
6.	I consent to the person I am consenting for's General Practitioner being informed about their taking part in PLINTH	*Initial here*
7.	Relatives, carers, or close personal contacts named on the Contact Form are willing to provide information about how the person I	*Initial here*

STUDY ID: _ _ _ _ _ _

Welfare Attorney/Welfare Guardian/Nearest Relative Consent Form

IRAS reference number: 325272 **REC number**: 23-SS-0087

am consenting for is getting on. These people or others caring for my them may provide this information if they cannot be contacted or they are not able to make their own decisions.

8. I agree to the person I am consenting for taking part in PLINTH. | *Initial here* |

Tick Yes or No to indicate your preference for these optional parts of the study:

9. If the person I am consenting for withdraws from the study, the study can keep and use any information collected about them up to the point of exit from the study	*Yes*	*No*
10. I agree to complete a short survey about quality of life after a brain haemorrhage.	*Yes*	*No*
11. I agree to that routinely collected information held and maintained by central UK NHS bodies may be used to provide information about their health status.	*Yes*	*No*
12. I agree that information about the person I am consenting for may be used to support other research in the future, and may be shared anonymously with other researchers, whatever happens to them.	*Yes*	*No*
13. I would like to receive the results of PLINTH by email or post	*Yes*	*No*

_____
Print name of participant

_____ ___/___/_____ _____
Print name of person taking consent **Date** **Signature**

_____ ___/___/_____ _____
Print name of person providing consent on participant's behalf **Date**

I am (✓ one): ☐ Welfare Guardian / Welfare Attorney
☐ Nearest relative

When completed, please: give one copy to the participant, send one copy to the trial coordinating centre, file one copy in the participant's medical records, and file the original in the investigator site file.