Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Sligo/Leitrim Mental Health Service,
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Research Subject Information Sheet

1. Study title

Biomarkers for cognitive recovery in elderly medical inpatients.

2. Invitation

You are being invited to take part in a research study. Please take your time to read the following information and to discuss it with any person if you wish. Ask us if there is anything that is not clear to you or you would like more information.

3. What is the purpose of the study?

Some people coming into hospital become temporarily forgetful or disorientated. We are studying this with the eventual aim of developing treatments that may reduce this problem. But first we have to find out more about the course of these states and we are therefore asking for your help.

4. Why have I been chosen?

We are trying to approach all of the older people admitted into the medical wards at this hospital.

5. Do I have to take part?

It is entirely up to you whether you take part. If you decide to participate and later change your mind, you are free to do so at any time, without having to give any reason. In any case (if you take part, withdraw, or not take part) your treatment will be exactly what would normally be given for your condition and your care will not be affected in any way.

6. What will happen to me if I take part?

We would like to:

- ask you some questions about how you are feeling and give you a brief memory test. We will do this about four times over a one month period. On each occasion we will spend about half an hour with you and we will ask for your permission each time.
- look at your records and record information about your diagnosis, medications and how you recover.
- take blood sample from you, after the memory test. We will test the blood sample for several markers, which we believe may be of importance in affecting the way in which people recover from episodes of deterioration or forgetfulness. The samples will be completely anonymised so there is no way of linking the information about the sample to you. The results of the special markers will therefore not be given to you.

7. What are the possible disadvantages and risks of taking part?

There are no additional risks associated except discomfort when the blood was taken. There are no risks associated with the other tests we are performing.

8. What are the possible benefits of taking part?

There will not be any direct benefit to you in participating, but we hope that the information we get from this study will help us understand, and to treat, future patients with confusion better.

9. What will happen to the results of the research study?

If the results of this study are published no information that could possibly identify you will be released.

10. Contact for Further Information

If you need more information please do not hesitate to contact Dr Geraldine McCarthy, Consultant in Psychiatry of Old age. Phone no 071 9192200

This study has been reviewed and approved by the Research Ethics Committee at Sligo General Hospital.

Thank you considering this invitation.

Dr. Geraldine Mc Carthy MB Bch BAO DCH M.R.C.Psych
Consultant in Psychiatry of Old Age
Comunity Base, Liscarney House,
Pearse Road, Sligo (071) 9192200

CONSENT FORM

I (name) _____
of (address) _____

_____

hereby consent to take part in the above investigation, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without necessarily giving a reason for doing so and that this will in no way affect the care I receive as a patient

I do not want to give blood ☐

I will give blood ☐

SIGNED (Volunteer) _____ **Date** _____

(Doctor/Investigator) _____ **Date** _____

(Witness, where appropriate) _____ **Date**_____

ASSENT FORM (proxy consent)

I (name) _____
of (address) _____

_____
Next of kin/legal representative of

(name) _____
(address) _____

_____

hereby assent my relative to take part in the above investigation, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw the assent at any stage without necessarily giving a reason for doing so and that this will in no way affect the care that my relative receive as a patient

I do not want my relative to give blood ☐

I assent my relative to give blood ☐

SIGNED (legal representative/next of kin) _____ **Date** _____

(Doctor/Investigator) _____ **Date** _____

(Witness, where appropriate) _____ **Date**_____