scientific studies. Your samples will not be transferred outside of the UK.

These samples may be used for genetic testing for specific biomarkers of inflammation that can have an effect on seizure risk.

The samples will be kept in a secure place until we need them; nobody outside of the study will have access to **any** confidential information that you give to us. Confidential details (such as your address and GP details) will be kept locally and not made available to collaborators.

Separate funding and approval will be sought for any future research that involves your samples.

If you choose to withdraw from the study, we won't collect any more samples from you, but we will continue to store the samples we have already collected and these will be made available to future researchers. If you do not want us to do this, please let us know and we will stop where possible. It may however not be possible to stop this where the samples have already been provided to researchers.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak with one of your research team who will do their best to answer your questions.

If you remain unhappy and wish to complain formally, you can do this by contacting local NHS Patient Advice and Liaison Service (PALS) or equivalent. Members of your local hospital team should be able to provide this information to you.

Every care will be taken of you in the course of this clinical study. However, in the unlikely event that you are harmed by taking part in this research project of the study Sponsor (University of Liverpool), compensation may be available and you may have to pay your related legal costs. Your hospital where you receive your treatment has a duty of care to you whether or not you agree to participate in the study and the study Sponsor accepts no liability for negligence on the part of your hospital's employees. However, if you are harmed and this is due to someone's negligence at the hospital, then you may have grounds for a legal action for compensation against the NHS Trust where you are being treated but you may have to pay for your legal costs. The normal National Health Service complaints procedures should be available to you.

Thank you for taking the time to read and consider this information sheet. Should you decide to take part in the study, you will be given a copy of the information sheet and a signed consent form to keep.

<Trust/Site address 1>
<Trust/Site address 2>
<Trust/Site address 3>
<postcode>
Tel: <telephone number>

FOR SITE USE ONLY:

Site Name:																			
Participant Screening No.:																			
Participant Initials:				Participant DOB:			/			/									

Adult/Young Adolescent Consent Form

To be completed by the participant:

Once you have read and understood each statement please enter your initials in each box.	Initial
1. I have read and understood the information sheet for this study. I have had the opportunity to ask questions and have had these answered satisfactorily.	
2. I understand that participation is voluntary and that I am free to withdraw from the study at any time, without giving a reason, and without my care or legal rights being affected. However, the study team may need to collect some limited information for safety reasons.	
3. I agree to take part in the above study.	
4. I give permission for a copy of this fully completed consent form to be sent to the LCTC (where it will be kept in a secure location) to allow confirmation that my consent was given.	
5. I understand that relevant sections of my medical notes and any data collected during the study may be looked at by authorised individuals from the central study team and representatives of the Sponsor, regulatory authorities and the local NHS Trust. I give permission for these individuals to have access to my records and data.	
6. I agree to my GP being informed of my participation in the study.	
7. I agree for the relevant data on my NHS hospital admissions and treatment to be collected for the purposes of this study and understand this will involve accessing data from my hospital's finance office.	
8. I agree for the relevant data on my NHS hospital admissions and treatment to be collected for the purposes of this study and understand this will include accessing electronic NHS health care records from NHS Digital (England) for the financial years commencing 6 months before the start of the study and covering the duration of the study, for health economic analysis **(for England only)**.	
9. I agree for my personal data (including name, postcode, date of birth, NHS number) to be shared with NHS Digital (England) so they can provide Health Economic researchers working on the study with information regarding my medical data and hospital attendances **(for England only)**.	
10. I agree for my medical data held by NHS Digital (England) to be obtained by Bangor University for use on this study **(for England only)**.	
11. I understand that my data will be kept by the University of Liverpool, Bangor University, The Walton Centre NHS Foundation Trust, Cambridge Neurosurgical Laboratories, and at my hospital in a confidential manner for 15 years from the end of the study.	

NHS number:										
Postcode:					-					

<Trust/Site address 1>
<Trust/Site address 2>
<Trust/Site address 3>
<postcode>
Tel: <telephone number>

FOR SITE USE ONLY:

Site Name:																					
Participant Screening No.:																					
Participant Initials:				Participant DOB:			/			/											

Adult/Young Adolescent Consent Form

The statements below are optional (you can still take part in the study even if you do not wish to agree to these): Please enter your initials in each box if you agree to the statements below. **If you do not agree, please leave blank**.

12. I agree to allow information and data or results arising from this study to be used in future healthcare and/or medical research providing my confidentiality is maintained. ☐

13. I agree that I may be contacted in the future in relation to this or other related studies. ☐
(if you agree to this statement provide your details below):

Telephone number:	
Email address:	

To be completed by the participant:

Your full name (please print):			
Your signature:		Date:	

To be completed by the Researcher (after participant has completed the form):

Researcher full name (please print):			
Researcher signature:		Date:	

Please make two copies: one for the participant and one for the medical notes. Please upload a scanned copy to REDCap for LCTC. Please file the original wet-ink copy in the STOP'EM Investigator Site File.

To be completed by the Translator (if used):

Translator full name (please print):			
Translator signature:		Date:	

To be completed by the Impartial Witness (if used):

Witness full name (please print):			
Witness signature:		Date:	
Participant's full name (please print):			