

Comparing two treatments for Grave's Disease

Patient 12 – 15 years Assent Form v2.0 28 MAY 2025

CONFIDENTIAL ONCE COMPLETED

Site ID Participant ID Principal Investigator: _____

Please tick
Yes or No in
the boxes:

1	I have read and understood the RiGD2 Participant Information Sheet 12-15 Years version _____ dated _____.	Yes ☐	No ☐
2	I know what the trial is about. I have been able to ask questions and I am happy with the answers given.	Yes ☐	No ☐
3	I know I do not have to take part, I can stop any time, and I do not need to give a reason.	Yes ☐	No ☐
4	I am happy for my GP/doctor to be told I am taking part.	Yes ☐	No ☐
5	I know I have to have some specific tests done to be eligible for the trial e.g. Hepatitis and Tuberculosis	Yes ☐	No ☐
6	I know that I will have some blood taken at each visit to check how I am doing and see if my medication dose needs to be changed.	Yes ☐	No ☐
7	I know that I will have to give a sample of my pee or a blood sample to be tested for pregnancy. (If you are biologically male do not tick a box)	Yes ☐	No ☐
8	I know that as part of the trial I will have a small tube put into a vein and be given an infusion of either the rituximab or the salty water.	Yes ☐	No ☐
9	I am happy to complete the questionnaires for the trial.	Yes ☐	No ☐
10	I am happy for my information to be used in the trial and stored for 25 years even if I become unwell or stop being in the trial.	Yes ☐	No ☐
11	I am happy for the people working on the trial to look at my medical notes.	Yes ☐	No ☐
12	I know that my trial information might be shared with other researchers at the end of the trial. I know that my name and my other personal information will not be included.	Yes ☐	No ☐
13	I know that information from the trial will be put in scientific reports, talked about at scientific meetings and shared with other doctors and scientists both inside and outside the UK. I know that any personal information about me will be kept safe and will not be made public.	Yes ☐	No ☐
14	I am happy that information from the trial will have my name and other personal information removed and will be stored outside of the hospital. No one will know that the information belongs to me.	Yes ☐	No ☐
15	I agree to take part in the trial.	Yes ☐	No ☐

STOP and check that you have put a tick in all the boxes you wanted to.

Name of Participant

DD MMM YYYY

Signature

Name of Person receiving Assent

DD MMM YYYY

Signature

When completed: File original in the investigator site file; Provide copy for the study participant; File/upload copy to the participant's medical notes.