

Sleep for Stroke Management and Recovery Trial

Date:

(Date)

Patient’s address:

(Participant’s Address)

Dear ,

(Participant’s Name)

On , you consented and enrolled in the Sleep SMART trial at

(Date)

 .

(Location of enrollment)

The purpose of the trial is to determine whether treatment of obstructive sleep apnea (OSA) with continuous positive airway pressure (CPAP) improves recovery from stroke and helps prevent strokes, heart attacks, and death. It is important that we follow your health status while you are enrolled in this trial. This is true whether or not you are using CPAP.

Several attempts have been made to contact you for follow-up without a reply. I am sending this certified letter after repeated attempts to reach you have failed.

Please call my office at the number below, so we can discuss follow-up.

If I do not hear back from you after receipt of this letter, I will stop trying to reach you. However, please feel free to contact me at any time about continuing in the trial. As a reminder, you will be given $75 for completing the outcome assessment. We can perform the visit over the phone if that is your preference. If you decide not to continue in the trial, you will no longer be followed by the research team and you should seek care from your primary care physician for stroke prevention, OSA and any other health concerns you may have.

I can be reached at .

(trial staff phone number)

If I am not available when you call, please leave a detailed message including phone number and best time to reach you. I will return your call as soon as possible.

I want to personally thank you for your participation in the Sleep SMART trial and I look forward to hearing from you soon.

Sincerely,

Name of PI or Research Coordinator

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