PATIENT WITHDRAWAL FORM

Please Print

Keep original in clinic file
Please send copy to BBPSP Attn: T. Soll Fax:780-401-3067

Patient CHR Number _____ Date _____

Clinic Name:

This patient wishes to withdraw from the study. The samples will:

☐ **Remain in the Study**

_____ _____
Patient Signature Witness Signature

☐ **Be destroyed**

_____ _____
Patient Signature Witness Signature

_____ _____ _____
PI/Nurses Name (Printed) Date Signature

BBPSP (do not write in this area)

☐ Sample Destroyed Date: _____

Destroyed By: _____

Notes:_____