Clinical Relevance Of Microbleeds In Stroke

Study Withdrawal Form

Please complete this form in the following circumstances:

1. If the patient or consultee wishes to withdraw from the study
2. If the patient or consulttee wish to stop patients's ongoing participation in the study after the study has completed
3. If the patient is withdrawn from the study for any other reason

Please complete in black ballpoint pen

Part A: Patient details

Name of hospital _____

Study number (5 digits) ☐☐☐☐☐ Date of birth: __/__/__

Patient's surname_____

Patient's first name _____

Points to remember when completing this form:

- A patient has the right to withdraw from the study at any time and for any reason, without prejudice to their medical care. They are not obliged to provide a reason for their change of mind.
- Please clarify with the patients whether, despite withdrawing consent, they would agree for data collection to continue and any outstanding data collected.
- Ensure the fact the patient has withdrawn is recorded in the patient notes.

Part B: Details

B1. Date of withdrawal from the study ____/_____/____

B2. Why was the patient withdrawn? (Please tick one of the following)

Patient wish ☐
Other ☐

Please list any further information:

B3. Has the patient agreed that the data already collected can be used? Yes ☐ No ☐

Part C: Details of person completing form

C1. Date this form was completed __/__/__

C2. Name of person completing this section of the form

Name (Print)_____
Signature_____

When this form has been completed make a copy, return the original to the Study Office and place the copy in the patient medical notes. Please ensure all questions on this form are answered.

If you have any questions about this form or how to answer any of the questions please contact the Study office on 020 7 676 2194.