

## Withdrawal from BUMPES

Please complete using a **black** ballpoint pen
Please complete if a women decides to withdraw from BUMPES after study entry.

General information		
Name of hospital:		
Date and time of withdrawal:		DD/MM/YY hh:mm
Woman's identification		
BUMPES study number:		
Date of birth:		$ \begin{tabular}{ c c c c c c c c c c c c c c c c c c c$
Withdrawal		
Reason for withdrawal:		
At the woman's request	Reason if known:	
Other	Please describe:	
May we use the woman's data up to point of withdrawal		Yes No
May we obtain outcome information from hospital records		Yes No
May we contact the woman at one	year eyear	Yes No
Health Professional's name in block capital letters:		
Health Professional's position:		
-		Date: DD/MM/YY
Signature:		Date. [D]D]/[M]M]/[T]T]
Please fax this form to the BUMPES Co-ordinating Centre:		



Clinical Trials Unit, BUMPES Study, UCL Gower Street, London, WC1E 6BT Telephone: 0207 679 0939 Email: bumpes@ucl.ac.uk www.instituteforwomenshealth.ucl.ac.uk/bumpes

0207 679 6761

