



# Withdrawal from BUMPES

Please complete using a **black** ballpoint pen

Please complete if a woman decides to withdraw from BUMPES after study entry.

## General information

Name of hospital: \_\_\_\_\_

Date and time of withdrawal: DD / MM / YY hh : mm  
24hr

## Woman's identification

BUMPES study number: \_\_\_\_\_

Date of birth: DD / MM / YY

## 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 Yes  No

Health Professional's name in block capital letters: \_\_\_\_\_

Health Professional's position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: DD / MM / YY

**Please fax this form to the BUMPES Co-ordinating Centre:  
0207 679 6761**

