

Withdrawal from BUMPES

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

Please complete if a women decides to withdraw from BUMPES after study entry. General information Name of hospital: ___ D D / M M / Y Y h h : m m Date and time of withdrawal: Woman's identification BUMPES study number: Date of birth: 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 No May we obtain outcome information from hospital records No May we contact the woman at one year No Health Professional's name in block capital letters: Health Professional's position: Date: D D / M M / Y Y Signature: _ Please fax this form to the BUMPES Co-ordinating Centre:





