LOGO

*STUDY NAME*

**STUDY WITHDRAWAL**

You have indicated that you would like to withdraw from the study and have communicated this information to your study doctor. You have the right to withdraw fully from this study at any time and you do not have to give a reason. However it is possible to withdraw only from certain parts of the study, and we would be grateful if you would consider the different options.

Withdrawing either fully or partly will not prejudice your future medical care.

Read this form carefully. Ask a member of the study team if you have any concerns and make sure you receive satisfactory answers to your questions before you sign it. Your participation in the study remains confidential and results will only be available as outlined in the main consent form you signed at the start of the study.

Please discuss your options and intentions with your doctor, study staff and relatives before withdrawing. You have many options for continuing in the study. It is important for the staff to understand exactly which aspects of the study you wish to discontinue.

**WITHDRAWAL OPTIONS**

Please tick one:

|  |  |  |
| --- | --- | --- |
| 🞏 |  | I want to stop taking the study medication.  &  I am willing to continue all other study procedures and attend scheduled visits. |
| 🞏 |  | I want to stop taking study medication and stop scheduled study procedures.  &  I am willing to participate in periodic interviews (for example, every 2 months). |
| 🞏 |  | I want to stop taking study medication, stop scheduled study procedures, and stop participating in interviews.  &  I am willing to allow study staff to regularly review my records. |
| 🞏 |  | I want to stop participating in all aspects of the study and fully withdraw my consent. |

If you are willing to be contacted for follow-up outside of the clinic, please provide the best way of contacting you and an emergency contact:

Your contact details:

|  |  |
| --- | --- |
| Phone |  |
| Email |  |

Emergency contact details:

|  |  |
| --- | --- |
| Name: |  |
| Phone: |  |
| Email: |  |

I may be contacted at the end of the study regarding my health status: Yes🞏 No🞏

(tick one)

By signing this form, you confirm that you have had enough time to review this form and all of your concerns and questions have been answered to your satisfaction.

I withdraw my consent for participation in this study in accordance with the withdrawal option I have selected above.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Participant’s signature |  | Date |  | Participant’s name (please print) |
|  |  |  |  |  |
| Signature of staff reviewing options |  | Date |  | Name of staff reviewing options  (please print) |

**To be completed by site staff**

**Participant ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**