

WITHDRAWAL FORM

Please complete this form if a parent chooses to withdraw from the study, and attach it to the baby's CRF booklet.

Baby's Details

1. First Name:	**ATTACH BABY ID STICKER HERE**
2. Last Name:	
3. Study number: 1 2	
4. Baby's NHI:	

Withdrawal Details

6. Date of withdrawal:

d	d		m	m		2	0	y	y
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 7. Time of withdrawal (24 hr clock):

h	h	m	m
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5. Type of withdrawal (please tick Yes or No for all questions):

	YES	NO	
5.1	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from intervention / study gel (before gel given)?
5.2	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from use of i-Stat analyser for blood tests?
5.3	<input type="checkbox"/>	<input type="checkbox"/>	Withdraw permission to collect data from baby's medical records?
5.4	<input type="checkbox"/>	<input type="checkbox"/>	Withdraw permission to collect data from mother's medical records relevant to this pregnancy?
5.5	<input type="checkbox"/>	<input type="checkbox"/>	Withdraw permission to contact when baby is 3 days old for follow-up?
5.6	<input type="checkbox"/>	<input type="checkbox"/>	Withdraw permission to contact when baby is 6 weeks old for follow-up?
5.7	<input type="checkbox"/>	<input type="checkbox"/>	Withdraw permission to contact in the future e.g. 6 months, 2 years, for possible follow-up?

5. Reason for withdrawal (please tick all appropriate options and provide reasons if possible):

6.1 Parent's decision _____

6.2 Clinician's decision _____

6.3 Adverse event(s) – please complete a Serious Adverse Event Form if applicable _____

6.4 Other _____

7. Any additional feedback the parent(s) wishes to give regarding the trial?

Full name of person completing this form: _____	Job title: _____
Contact phone number at work: _____	Mobile number: _____
Signature: _____	<i>Please attach this form to the baby's hPOD CRF booklet</i>

*** DO NOT FILE THIS FORM WITH THE BABY'S CLINICAL NOTES ***