



PATIENT WITHDRAWAL FORM

Please Print

Keep original in clinic file
Please send copy to BBPSP Attn: T. Soll Fax:780-401-3067

Patient CHR Number _____ Date _____

Clinic Name: _____

This patient wishes to withdraw from the study. The samples will:

<input type="checkbox"/> Remain in the Study	
_____	_____
Patient Signature	Witness Signature
<input type="checkbox"/> Be destroyed	
_____	_____
Patient Signature	Witness Signature

PI/Nurses Name (Printed) Date Signature

BBPSP (do not write in this area)

Sample Destroyed Date: _____

Destroyed By: _____

Notes: _____
