



ARTIC PC Withdrawal form

Participant ID □ □ / □ □ □ □

Participant DoB DD/ MM / YYYY

GP Site ID □ □ □

GP Site name

Type of withdrawal (please tick all that apply)

- | | |
|-------------------------------------|--------------------------|
| All data collected | <input type="checkbox"/> |
| Taking trial medication | <input type="checkbox"/> |
| Receiving follow up telephone calls | <input type="checkbox"/> |
| Symptom diary completion | <input type="checkbox"/> |
| Use of data collected so far | <input type="checkbox"/> |
| No reason given | <input type="checkbox"/> |

Please add any further information if known below

Details of person completing form

Print nameSignature

Date DD/MM/YYYY

Fax the completed form to the study office in Southampton on 023 8000 2380 and file the original in your site file.