A PROJECT OF THE BRITISH ASSOCIATION OF DERMATOLOGISTS

PATIENT WITHDRAW FORM – Parent/carer

Title of Project:
The UK-Irish Atopic eczema Systemic TherApy Register (A*STAR)

We would like to thank you for the time you and your child have given to this study. We understand that you do not want to participate any further in the study. Please be assured that this will not affect your child's standard of care in any way.

Please initial the option that better describes what you wish to do:

Please initial box

1. I do not want my child to continue completing patient questionnaires, but he/she will continue in the study otherwise. ☐
2. I no longer wish my child to actively continue in this study, but you may use the data already collected, review future medical records and link to the child's data for long term follow up. ☐
3. I no longer wish my child to actively continue in this study. You may use the data already collected **but** not review future medical records or link to my child's data for long term follow up ☐
4. I wish to withdraw consent from all parts of the study. I do not wish for my child's data from this study to be linked with other sources of healthcare data. ☐

Additionally, if you consented for your child to participate in the biorepository section, please initial the options that better describe what you wish to do (you may tick more than one):

5. I do not wish my child to provide any further research skin or blood samples, **but** I allow for you to carry on with any analyses of the samples collected so far. ☐
6. I do not wish for my child's samples to be stored in the tissue research bank for use in future studies. ☐
7. I no longer wish my child to be contacted about future research. ☐
8. I wish for **all** my child's samples to be destroyed. ☐

We would be grateful if you could describe the reason(s) why you are withdrawing consent. You do not have to provide a reason if you don't wish to, but it is helpful for us if you do:

Name of patient		
Name of person with parental responsibility for the patient	*Date*	*Signature*
*Name of delegated A*STAR staff member*	*Date*	*Signature*
Name of witness (if applicable)	*Date*	*Signature*

1 original for patient; 1 original for researcher; 1 copy to be kept with hospital notes