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Surname		
Name		
Date of Birth		

## CONSENT WITHDRAWAL FORM

### Investigators:

Dr Luciano Dalla-Pozza, Department Head, Oncology Unit, Tel: (02) 9845 2134  
 A/Prof Daniel Catchpole, Head of Tumour Bank, Children's Cancer Research Unit, Tel: (02) 9845 1205

### Request to withdraw consent (tick those that are appropriate):

- I hereby no longer wish for the Tumour Bank at The Children's Hospital at Westmead to continue to collect and store my/my child's left over biological material, and request for any stored samples to be destroyed
- I understand that any samples that have already been supplied to be used in a research project cannot and will not be retrieved
- I understand that withdrawal of my consent will not jeopardise my/my child's treatment or our relationship with The Children's Hospital at Westmead, now or in the future
- I would like a written notification from the Steering Committee about the outcome of my request for a withdrawal.

Caller Name  
*(ensure this is a authorised person to make this call)*

Reason for withdrawing *(if given)*

Job Title of researcher taking the call

Name of researcher

Signature of researcher

Date



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