Hôpitaux Universitaires Genève

Neurosurgery Department

Statement of withdrawal of consent

Please read this form carefully. Do not hesitate to ask questions when you do not understand something or want clarification.

BASEC number of the research project (after submission to the competent ethics commission):	2023-XXXX
Title (scientific and usual):	**Middle Meningeal Artery Embolization for Chronic Subdural Hematomas: A Randomized Clinical Trial to Determine the Likelihood of Recurrence After Embolization** **Middle Meningeal Artery (MMA) Embolization for cSDH: Rationale and Design for the STOp Recurrence of MMA Bleeding (STORMM) Randomized-Control Trial**
Responsible Institution (Sponsor and Full Address):	Pr. Karl Schaller Neurosurgery Department Department of Clinical Neurosciences HUG Rue Gabriel-Perret-Gentil, 4 1211 Geneva 14 Phone: +41 (0)22 372 82 02 email : Karl.Schaller@hcuge.ch
Place of production:	Department of Neurosurgery, HUG
Investigator in charge on the site: Name and first name in print:	Dr. Aria Nouri Neurosurgery Department, Department of Clinical Neurosciences HUG Rue Gabriel-Perret-Gentil, 4 Phone: +41 (0)795530958 Email: Aria.Nouri@hcuge.ch
Participant: First and last name in print: Birth date:	

- I declare that I have informed the team of the above-mentioned research project of the withdrawal of the patient's consent for his or her participation in this project.
- I would like the patient's data to be stored in the form of:
  - ☐ Encoded: The data can only be linked to the patient by means of a key.
  - ☐ Anonymized: the code linking the patient's data to his or her person will be deleted, so no one will be able to know that this data is theirs. This process is primarily intended to ensure the protection of my data. I know that if I choose to have the data anonymized, I will no longer be able to be informed of any chance discoveries.

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Location, date	First and last name in print Relationship with the patient: ☐ Person named in advance directives or in a power of attorney ☐ Curator ☐ Spouse or partner registered and providing regular personal assistance ☐ Person living in common with the participant and providing regular personal assistance ☐ Descending and providing regular personal assistance ☐ Father/Mother and providing regular personal assistance ☐ Brother/Sister and providing regular personal assistance Signature of the relative or legal representative:
Name and first name of the investigating physician in block letters.	
Signature of the investigating physician	

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