INFORMED CONSENT STATEMENT

The department or hospital ______________ supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study.

**Background:**

We are currently participating in an international, observational, multicenter registry on management of women with Type 2B VWD during pregnancy and the postpartum period. Type 2B VWD accounts for about 5% of all cases of von Willebrand disease (VWD). It is usually characterized by moderate to moderate-severe bleeding tendency. The VWF does not function properly and attaches to platelets in the bloodstream, instead of binding at the site of the injury to the blood vessel. This can cause a shortage of platelets.

The aim of this registry is to better understand management of women with type 2B VWD during pregnancy or postpartum delivery. This is an observational registry, and no experimental drugs will be tested. Your participation or non-participation in the registry will not influence your medical management or treatment.

**What data are we collecting?**

We will collect medical information on your pregnancy, the Type 2B VWD, its treatment and impacts on you and your baby. There are no planned follow-up visits.
Confidentiality:
To protect your confidentiality, your name will not be associated in any way with the information collected about you or with the research findings from this study. The researchers will not share personal information about you unless you give written permission.

Participation is voluntary:
You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you do withdraw from this study, it will not affect your relationship with this unit, the services it may provide to you, or this hospital. You may withdraw your consent to participate in this study at any time, even after giving your initial permission. If you wish to cancel, please communicate this in writing to your treating physician. They will inform us about your request so the researchers will stop collecting additional information about you. However, the research team may use and disclose information that was gathered before they received your cancellation.

Benefits and risks:
By participating you are helping physicians better understand the effect of Type 2B VWD on pregnancy and the impact on mother and baby. This will help many patients around the world. There are no risks. Whether you participate or not, this will not affect your relationship with this hospital or institution. You will continue to receive the services you need.

___________________________________________________________
Type/Print Participant's Name

___________________________________________________________
Participant's Signature                                         Date

___________________________________________________________

Researcher Contact Information: