

Pre **OUTPATIENT VISIT** DATA FORM

General Clinical Research Center (Robert Sherwin, MD, Program Director)

GCRC Adult 10-6 (Fax 203 688-3100)

Pre-visit form to be filed with secretary. If there are any questions, call the CGRC secretary (203 688-4106).

Visit #: _____ for Protocol # _____		Expected time of subject arrival: _____ a.m. _____ p.m.	
Patient Name: _____		Expected length of appointment: _____ hrs. _____ min.	
Last name	First name	MRUN/Unit # _____	
Marital Status: _____		Date of birth: _____	
Maiden name: _____		Pt's Gender: M F	Place of Birth: _____
Address: _____			
Street	City	State	Zip
Telephone: Home (_____) _____		Work (_____) _____ (be sure to list)	
Cell phone: (_____) _____		Does subject speak English? Yes _____ No _____	
Deaf/hearing impaired?		If not, what language do they speak? _____	
Yes _____	No _____	Race: (check all that apply)	
Assistance needed for communication? _____		<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian	
Ethnicity:		<input type="checkbox"/> Black or African American <input type="checkbox"/> White	
<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> More than one Race	

Attending / Responsible Physician: _____ **Tel. #** _____ **Pager #** _____

Service: Pediatric Medicine

Diagnosis (if applicable) and **Dx Code** _____

(No Abbreviation)

Person to be notified in case of an emergency:

Name: _____ Phone Number: _____

Relationship: _____

Address: _____

Street City State Zip

HIC Protocol # _____	Person conducting study: _____
PI fax# for GCRC Confirmation of visit date _____ PI Phone # _____	
<i>Investigator: Please check off any box that will be completed prior to GCRC visit.</i>	
CONSENT SIGNED? <input type="checkbox"/> Yes <input type="checkbox"/> No HIPAA RAF <input type="checkbox"/> Yes <input type="checkbox"/> No NOPP <input type="checkbox"/> Yes <input type="checkbox"/> No	
Form submitted by: _____	Date: _____