

VISIT DATE: _____

CSRU OUTPATIENT VISIT REQUEST and DATA FORM
Yale Center for Clinical Investigation (Robert Sherwin, MD, Program Director)
CSRU, 2 Church St, Suite 401 (Fax: 203-785-7450)

*This Pre-visit form is to be filed with the clinic coordinator.
If there are any questions, please call the YCCI, 2 Church Street Research Unit at 203-785-7421.*

Protocol # _____	Visit # _____	Expected time of arrival: _____
		Expected length of visit.: _____ hrs. _____ min.
Patient: _____		<input type="checkbox"/> Phlebotomy-Expected length of visit.: _____ hrs. _____ min.
Last name First name		<input type="checkbox"/> Lab- Expected length of visit.: _____ hrs. _____ min.
		<input type="checkbox"/> Conference- Expected length of visit.: _____ hrs. _____ min.
Date of birth: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	MRUN/Unit # _____
Place of Birth: _____		Marital Status: _____
Address: _____		Maiden name: _____
Street City State Zip		
Telephone: Home: (____) _____		Work: (____) _____
Cell: (____) _____		Ethnicity: (check one)
<input type="checkbox"/> Assistance needed for communication (select below)		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Deaf or hearing impaired		Race: (check all that apply)
<input type="checkbox"/> Patient speaks other language: _____		<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian
		<input type="checkbox"/> Black or African American <input type="checkbox"/> White
		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
		<input type="checkbox"/> More than one Race

Attending / Responsible Physician: _____

Tel. # _____ - _____ - _____ Pager # _____ - _____ - _____

Diagnosis (if applicable) and Dx Code:

N/A

(No abbreviation)

Person to be notified in case of an emergency: _____

Relationship: _____

Phone Number: _____

Address: _____

 Street City State Zip

HIC Protocol # _____ Principal Investigator (PI): _____

Fax#: _____ - _____ - _____ (for CSRU Confirmation of visit date)

PI Phone #: _____ - _____ - _____

Please check off any box below that will be completed prior to patient's CSRU visit:

CONSENT SIGNED? Yes No

HIPAA RAF Yes No

Form submitted by: _____

Date: _____