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| **Research Information** |
| IRB Number |       |
| Protocol Number |       |
| Principal Investigator Name |       |
| National Clinical Trial Number |       |

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| **Patient Information** |
| Patient Name |       |
| Date of Birth |       |
| Patient MRN |       |
| Service Location | [ ]  UMC Hospital [ ]  UMC Facility [ ]  Non-Affiliated UMC Facility |
| Study Visit and Date | Visit Name:       Date:        |

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| **Visit Information** |
| Item/Service Name | CPT Code | Routine Care Required per Protocol | Research item billed to study |
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This form must be provided electronically to the Clinical Trials Office via research@umcsn.com within 24 hours of each patient corresponding study visits. The study team is responsible for notifying the Clinical Trials Office of each corresponding research visit and date.

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| **UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA:** |  |
| Submitted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |