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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](mailto: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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |