Long Outpatient (LOP) Request

Please complete all the requested information below and email the following forms packet to: LOPforms@columbia.edu

Participant Registration Information:

Requested Date of Admission:
Requested Time of Admission:

Participant Name:
MR#:

Protocol Name:
Protocol CRR#:

PI Name:
PI Email Address:
PI Telephone#:

Coordinator Name:
Coordinator Email Address:
Coordinator Telephone#:

Is this the participant’s first admission to Harkness 10 for this protocol?  Y  N
Are 3 or more blood samples required for this protocol?  Y  N
LONG OUTPATIENT RESEARCH PARTICIPANT ADMISSION SHEET

ADMISSION DATE__________________  ADMISSION TIME__________________

PARTICIPANT INFORMATION
Participant Name_________________________________________ MR# _______________ DOB __________
Gender (circle) □ M  □ F  Ethnicity______________________________________________
Address__________________________________________________ Tel. __________________________
City ___________________ State _______ Zip Code ________________
Mother’s Name_____________________________ Father’s Name______________________________
Emergency Contact__________________________________ Relationship_______ Tel. ___________________
Diagnosis (or healthy volunteer for research) ________________________________

STUDY INFORMATION
Admitting Service:__________________________
P.I. _____________________________________________ Phone/Cell____________________________
Admitting MD _____________________________ ID# ____________ cell phone# __________________
Research Coordinator________________________ cell phone# __________________
Study Name ________________________________ CRR # ____________ IRB # ______________
Study Type (check one):  Drug  Device*  Type:______________________________________________
Note to P.I.:  If device trial, has Medicare coverage been approved?  Yes  □ No  □ (If no, do not admit the participant)

SUBJECT INSURANCE INFORMATION
Guarantor Name____________________________________________ Phone # ___________________ Email ____________
Primary Insurance _________________________________ Policy # __________________________
Guarantor Address__________________________________________
City ___________________ State _______ Zip Code ________________
Secondary Insurance________________________________________ Policy # __________________________

RESEARCH BILLING INFORMATION : Please place an “X” next to the appropriate type of admission
_________A-Day (IICTR -G13) – Non-industry initiated study; Room & board is billed by the CRR to the P.I.; Ancillaries will be billed to the P.I. via NYP blue bill.
_________B-Day (Insurance Code) – Admission is split between participant insurance and study sponsor.
_________B-Day (Non- IICTR –Insurance Code) – Entire admission is covered by insurance, but specific tests will be billed to the study via NYP blue bill.
_________D-Day (IICTR -R10) – Industry initiated study – Room & board is billed by the CRR to the P.I.; Ancillaries will be billed to the P.I. via NYP blue bill.

Signature/Credentials________________________________________ Date____________________
Flow Sheet for Long Outpatient Visits on Harkness 10

Protocol Name: 

Protocol CRR#: 

PI: _____________________________ Coordinator: _____________________________

Contact number: _____________________________ Contact number: _____________________________

Protocol Flow Sheet for Long Outpatient Visits:

<table>
<thead>
<tr>
<th>Hour from Admission</th>
<th>Procedures</th>
<th>Nursing Duties</th>
<th>Researcher or Coordinators Duties</th>
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Specialized equipment required for your study (gases, liquids, solids, monitors):

Specimen collection tubes (type and number):

Infusates and medications (include those prepared by the research pharmacy):

Possible side-effects (clinical trials):