

COVID CLINIC RESEARCH FORM

APPOINTMENT REQUEST FORM

PLEASE SUBMIT ELECTRONICALLY OR EMAIL COMPLETED FORM TO

Carmen.Galarza@yale.edu

100 West Campus Drive, Orange, CT 06477

Visit Information	
<p>Date Submitted:</p> <p>HIC Number:</p> <p>Protocol/Study Visit #:</p> <p>Requested Visit Date:</p> <p>Expected Time of Patient Arrival: _____AM _____PM</p> <p>Expected length of visit: Hrs.: Min:</p> <p>Has Patient Signed Consent: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><small>*If the patient has consented, the consent form must be scanned into OnCore prior to the initial appointment. *If consent will occur at the COVID Clinic visit, the consent must be uploaded into OnCore by the close of business, same day as the visit.</small></p>	<p>Form Submitted by:</p> <p>PIName:</p> <p>PIPhone:</p> <p>Responsible MD (if PI is not an MD) :</p> <p>Responsible MD Phone:</p> <p>Responsible MD Email:</p> <p>Coordinator/RAName:</p> <p>Coordinator/RAPhone:</p> <p>Coordinator/RAEmail:</p>
Patient information	
MR Number:	Birth Date:
Last Name:	First Name, Middle Initial:
Maiden Name:	<p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Height: _____ Weight: _____</p>
Home Number: Cell Number:	<p>Does the patient speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If not, what language is spoken?</p>
<p>Is the patient deaf or hearing impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Is assistance needed for communication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Emergency Contact Name: Home Number:	Relationship: Cell Number: