

CSRU OUTPATIENT VISIT REQUEST and DATA FORM

EMAIL COMPLETED FORM TO: csrureservations@yale.edu

Yale Center for Clinical Investigation (Brian Smith, MD, Program Director)

CSRU, 2 Church Street So., Suite 401, New Haven, CT 06519

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 203-785-7421

VISIT INFORMATION

Today's Date: _____ HIC# _____

PI Name: _____ PI Phone: _____

Coordinator Name: _____ Coordinator Phone: _____

Has patient signed consent: ___ Yes ___ No Expected length of appt (total time): ___ Hrs. ___ Mins

Type of visit:

___ APRN ___ RN ___ Phlebotomy
___ Consultation Room ___ Space/Exam room only
___ EKG ___ Other _____

PROCESSING -(include lab manual):

Sample/Specimen (complete with volume amount)

Blood _____ Urine _____ Saliva _____

Buccal Swab _____ NP Swab _____ Other _____

Epic Order# _____

Will any material be transported back to PI's Lab? ___ Yes ___ No

Appointment Request information:

Visit#	Date	Time	Length

Visit#	Date	Time	Length

PATIENT INFORMATION

MR #: _____ Date of Birth: _____

Last Name: _____ First Name, Middle Initial: _____

Race: _____ Ethnicity: _____

Does the patient speak English: ___ Yes ___ No Is the patient deaf or hearing impaired: ___ Yes ___ No

Gender: _____ Height (inches): _____ Weight (lbs): _____

Address (Street/PO Box, City, State, Zip Code):

Home Phone: _____ Cell: _____ Work: _____

In Case of Emergency:

Name of relative/friend: _____ Relationship to patient: _____

Phone: _____