HRU INPATIENT/OUTPATIENT VISIT REQUEST and DATA FORM

EMAIL COMPLETED FORM TO: carmen.galarza@yale.edu

HRU, Yale New Haven Hospital, 20 York Street, 10th Floor, EP, New Haven, CT 06519

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 203-688-4106

VISIT INFORMATION

APPOINTMENT REQUEST: INPATIENT ____ OUTPATIENT ____

Today's Date: ______________________________

HIC: ______________________________________

Protocol/Study Visit#:_________________________

Requested Visit Date:_________________________

Expected time of patient arrival: _____AM ____PM

Expected length of stay (# of nights/inpatient)________

Expected length of stay (outpatients): ____Hrs. ____Min.

*Has patient signed the consent form? ____Yes ____No

If the patient has consented, the consent form must be scanned into OnCore prior to the initial appointment.
**If consent will occur at the CSRU visit, the consent must be uploaded into OnCore by the close of business, same day as the visit.*

PI Name _____________________________

PI Phone:_______________________________

PI Email:______________________________________

*Responsible MD Name: __________________________

*Responsible MD Phone: __________________________

*Responsible MD Email:___________________________

Coordinator Name:______________________________

Coordinator Phone:______________________________

Coordinator Email:______________________________

Form Submitted By:______________________________

**Responsible MD - if PI is not an MD*

PATIENT INFORMATION

MR #:________________________________

Date of Birth:________________________________

Last Name:______________________________

First Name, Middle Intial:________________________________

Race:____________________________________

Ethnicity:_______________________________________

Does the patient speak English:____Yes ____No

Is the patient deaf or hearing impaired:_____Yes_____No

Gender:_________________________________

Height (inches): ___________ Weight (lbs): ___________

Insurance Info:____

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

____

Home Phone: ____________________________

Cell: ____________________________

Work: ____________________________

In Case of Emergency:

Name of relative/friend: ______________________________

Relationship to patient:

Phone: ____ ______________________________