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| **DIRECTIONS:*** **To request an out-patient appointment for a research participant** complete and submit this form to the Central Scheduling-Research team at CSResearch@gmh.edu.
* **Submit this Form at least 48 hours prior to the date/time of the appointment request**. Research appointment requests are processed M-F, 8-4:30. Requests received immediately before the date/time being requested cannot be accommodated.
* **Appointment confirmation** **is routinely provided via email.** If the Submitter has not received email confirmation 24 hours prior to the requested appointment, please resubmit the request.

**If you have questions:*** Contact CSResearch@gmh.edu with questions specific to scheduling research visits.
* Contact the Office of Grant Administration at grants@gmh.edu with research related questions. You may also refer to the “Managing Patient Research Visits” Tip Sheet for guidance.

***NOTE:*** *Appointments for radiology services are requested by submitting the* [***“Research Patient Pre-Registration Form - Radiology”***](https://www.gradyhealth.org/static/office-of-grants-administration/)to the CT Scheduling team. All Forms & Tip Sheets can be obtained at the [OGA Website](https://www.gradyhealth.org/static/office-of-grants-administration/). |
| **The asterisks (\*) denotes required information** |
| **Research Study & Contact Information** |
| **Grady Plan Code\*** |       (e.g. E600. Refer to the study’s ROC Approval document) |
| **Ordering Clinician\*** |       |
| **PI Name\*** |       |
| **Requestor Name\*** |       |
| **Requestor Phone Number \*** |       | **Email\*** |       |
|  |
| **Appointment Request Information** |
| **Appointment Date\*** *(mm/dd/yy)* |       |
| **Appointment Time\*** |       |
| ***NOTE:*** It is the responsibility of the PI/designee to provide the confirmed date, time and appointment location to the patient. |
|  |
| **Patient Demographic Information** |
| ***NOTE:*** A patient MUST be “enrolled” into the referenced study in Epic prior to transmitting this form |
| **Last Name\*** |       |
| **First Name\*** |       | **Middle Initial** |       |
| **Date of Birth\*** *(mm/dd/yyyy)* |       | **Gender** |       |
| **Medical Record Number\*** |       | **Social Security Number** |       |
| [ ]  **Check, if a new MRN is required.** ***\*To obtain a new MRN,*** *provide the patient’s full name, date of birth, mailing address and phone number. Patients cannot be scheduled without the information required to obtain an MRN.*  |
| **Language** |       |
| **Address** |       |
| **City** |       | **State** |       | **Zip Code** |       |
| **Phone Number** |       |

**\*\* Remember to submit the *Research Patient Tracker Form* after each research visit.**