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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](mailto: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](mailto:CSResearch@gmh.edu) with questions specific to scheduling research visits. * Contact the Office of Grant Administration at [grants@gmh.edu](mailto: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.**