Intake Form Help

Patient Name (Last) **(First)**

Date of First Contact (DD/Mmm/YYYY) **Study ID**

Former Study ID

Date of Baseline CT (DD/Mmm/YYYY) **Medical Record Number**

Research Protocol ○ yes ○ no **Cancellation** ○ yes ○ no **Special Attention** ☐

How did you hear about our program? - **Specify**

Patient Information

Patient Contact Information Update

Patient Street Address **Apt #** **County**

City **State** **Zip** **Country**

Phone (Work) **Phone (Home)**

Email Address

Insurance Information Update

Medicare ○ yes ○ no

Insurance 1: Insurance 2:

Insurance 1 Member ID: Insurance 2 Member ID:

Insurance 1 Group Num: Insurance 2 Group Num:

Insurance comments:

Physician Contact Information Update

Physician's Name

Physician Street Address **County**

City **State** **Zip** **Country**

Physician's Phone **Physician's Fax**

Date of Birth (DD/Mmm/YYYY)

SSN

Parents' First Names **Mother** **Father**

It is important to identify two contacts. At least one needs to be at another address.

Emergency Contact (1) **Name** **Relation**

Address **Phone**

Emergency Contact (2) **Name** **Relation**

Address **Phone**

Phone Calls ◉ 0 ○ 1 ○ 2 ○ 3 ○ X **Letters** ◉ 0 ○ 1 ○ 2 ○ 3 ○ X

Patient Status active **Specify**

Date of Exit (DD/Mmm/YYYY)

DOD (DD/Mmm/YYYY) **COD**

Correspondence Record

Correspondence Date (DD/Mmm/YYYY)		**Date of Exam** (DD/Mmm/YYYY)	
Recipient	○ patient ○ physician	**Physician Name (if recipient)**	
Nature	-	**Specify**	
		Coordinator	

Has the participant signed the consent form?	○ no [INELIGIBLE] ○ yes
Date informed consent signed (DD/Mmm/YYYY):	
Name of individual obtaining consent:	
Have you given a copy of the consent form to the participant?	○ no ○ yes
Did patient allow storage of information for use in future research studies?	○ yes ○ no
Did patient allow use of information for DIRECTLY RELATED studies?	○ yes ○ no
Did patient allow use of information for UNRELATED studies?	○ yes ○ no
Would patient like to be contacted about further related studies?	○ yes ○ no