# Clinical Research Center (CRC)

**Participant Registration Form**

To schedule BSLMC CRC visits, please secure email this form with signed orders (required) and signed consent (if available) to the BSLMC CRC office ([BSLMC-CRC@bcm.edu](mailto:BSLMC-CRC@bcm.edu)). If you do not receive a confirmation email within two business days, please call 713-798-6024. BSLMC Administrative Approval is required to utilize the CRC.

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| --- | --- | --- | --- |
| Patient’s First Name: Last Name: Middle:  Study subject ID: MRN: | | | |
| Gender:  Male Female Date of Birth: SSN\*: | | | |
| Address:  City: State: Zip Code:  Home phone: Work phone: | | | |
| IRB # (study account): Healthy volunteer:  Yes  No | | | |
| Investigator name: Phone # & email: | | | |
| Coordinator name: Phone # & email: | | | |
| Study visit day/week/number\*: Visit date & time (CST):  \* As per schedule of events | | | |
| Visit day of the week: Estimated length of visit: | | | |
| Bed Number: 2001 Diagnosis code(s)\*: Z00.6 | | | |
| \* Please add primary diagnosis if not healthy volunteer | | | |
| **PATIENT TYPE** | | | |
| Will this visit be covered 100% by the research study?  Yes  No | | | |
|  | If no, will insurance verification be needed?  Yes\*  No - Medicare funded - HIC #: | | |
|  | | | \* If yes, enter insurance information below: |
| Insurance Company Name: Group Name: Group #:  Insured’s ID #: Policy #:  Claims Mailing Address/phone number: | | | |
| **Comments:** | |  | |

Note: The BSLMC CRC Office is responsible for scheduling CRC research visits. Investigators and study teams may not independently schedule CRC patients. For questions or concerns, call 713-798-6024. PAS please print labels to PR0949 on PRT1, port 10.78.116.230

\* Note: Social Security number is not required; however, it is helpful in reducing the likelihood of duplicate medical records

ed: 28June2018 - AEsquivel