Reference #: _____

CitAD

Patient and Caregiver Registration and Location
(PL-1)

Purpose: Record patient and caregiver location information for clinic records.

When: At enrollment visit and at any subsequent visit as needed to update information.

Completed by: CitAD certified personnel.

Information obtained from: Patient and/or caregiver.

Instructions: Remove patient ID label from patient ID label sheet provided by the CC and affix to this form in item 2. Write contact information for patient and caregiver. Update when contact information changes. See handbook for instructions on assigning codes for clinic, patient, caregiver, and visit identification. Enter section A into the computer to register the patient and complete the rest of the form. If the patient is ineligible for the trial, section A is still completed and entered into the database. However the rest of the form is left blank. **Do not send this form to CC.**

A. Clinic, patient and visit identification

1. Clinic ID: ____ ____ ____ ____

2. Patient ID:

Affix Patient ID label here

3. Patient four-letter code: ____ ____ ____ ____

4. Date form completed:

____ ____ – ____ ____ ____ – ____ ____
day month year

5. Visit ID: ____ ____

6. Form revision date:

1 1 – a u g – 0 9
day month year

7. Caregiver four-letter code: ____ ____ ____ ____

B. Patient contact information

8. Patient name

a. Last name:

_____
last name

b. First name:

_____
first name

c. Middle initial: ____
middle initial

9. Home telephone number:

_____
(area code) home number

10. E-mail address *(if applicable):*

_____
e-mail

11. Address:

_____
street

_____
street

_____
city & state

_____
zip code

12. Primary physician

a. Name:

_____
full name

b. Work telephone number:

_____
(area code) work number

c. Address:

_____
street

_____
street

_____
city & state

_____
zip code

13. Friend or family member (other than caregiver) to contact in case of an emergency

a. Name:

_____
name

b. Relationship to patient:

_____
relationship

c. Home number:

_____
(area code) home number

d. Work number:

_____
(area code) work number

e. Address:

_____
street

_____
street

_____
city & state

_____
zip code

C. Caregiver contact information

14. Caregiver name

a. Last name:

_____
last name

b. First name:

_____
first name

c. Middle initial: ____
middle initial

15. Telephone number(s)

a. Home number:

_____
(area code) home number

b. Work number:

_____
(area code) work number

16. E-mail address *(if applicable):*

_____
e-mail

17. Address:

_____
street

_____
street

_____
city & state

_____
zip code

D. Administrative information

18. Date form reviewed by study coordinator:

____ ____–____ ____ ____–____ ____
day month year

19. Study coordinator ID: ____ ____ ____

20. Study coordinator signature:

_____