CCTS Research Appointment Request Form

Appointment Information

Visit Location: (SELECT)

Date of visit:

Admit Time: (SELECT)

Duration of visit:

Check box if participant has any of these procedures on this visit?

☐ EKG* ☐ ARUP*

☐ Radiology* ☐ ARUP exempt (purple slip)

**Participant will need to be registered into uTRAC. Contact CRCE at 801-213-3601 if any questions*

Does this visit need Pharmacy Services (IDS)?

☐ Yes ☐ No

Treatment Plan in EPIC?

☐ Yes ☐ No

Participant Information

MRN	*MRN needs to be 9 digits long. Add zero(s) in front of number if less than 9 digits.		
Full legal name (Last, First)			
Nickname (optional)			
Date of Birth (MM/DD/YYYY)			
Sex (Gender)	☐ Male ☐ Female		
Home address			
Home phone			
Cell phone			
Ethnicity	☐ Hispanic/Latino ☐ Unknown/Info not available	☐ Not Hispanic/Latino ☐ Patient Opts Out/Refuses	
Race	☐ American Indian/Alaskan Native ☐ Native Hawaiian or other Pacific Islander	☐ Black/African American ☐ Patient Opt out / Refuse ☐ Unknown / Info not available	☐ Asian ☐ White ☐ Multiracial

Study Information

Protocol number		IRB Number		Industry Study?	(SELECT)
Principal Investigator					

What is needed on this visit?

Nursing:

Dietary:

☐ Breakfast Quantity:

☐ Lunch Quantity:

☐ Dinner Quantity:

☐ Snacks only Quantity:

SAVE FORM

(*Buttons may not work on Apple computers*)

CLEAR FORM