UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIIEW

RESEARCH REQUEST FORM

Research Request #

POST TO CHART: YES OR NO

NAME OF STUDY Protocol #

VISIT:								Patient Identity
SPECIMEN COLLECTED							Check box to indicate if sample will be	
								identified by name or non-name identifier:
DATE		E TO BE LECTED		TIME ACTUALL COLLECTED	Υ	HID	F	PATIENT e.g. Last name, First Name
			AM PM		AM PM			
			FIVI			T CODE		NAME:
						. 0052		DOB: SEX: M/F
U#								SEA. WITE
ORDERING PHYSICIAN/ PHYSICIAN #								
							PATIENT study ID #, Initials or PI Name,	
RESEARCHER NAME/PHONE TO CONTACT IF QUESTIONS							Initials	
COLLECTION INSTRUCTIONS: Completed request form provided by research coordinator.								
						. 04		p
LABORATO	RY PRO	CESSIN	IG INSTE	RUCTIONS IF	DIFF	ERENT T	HAN	ROUTINE PROTOCOL
CODE	СТ	Х	TEST:	VRITE IN	REC	QUEST	ED 7	TEST NAME BELOW
OE		Х	Order Entry Charge					
PR		Х	Processing Charge					
OVP			Venipuncture charge for 1 tube <i>If Fairview lab staff collect</i>					
OVP1			Venipuncture charge for 2-4 tubes <i>If Fairview lab staff collect</i>					
OVP2			Venipu	incture char	ge fo	r 5 or mo	re tub	bes If Fairview lab staff collect
HCC								
HSC Approval Date								