UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIIEW

RESEARCH REQUEST FORM

Research Request #

POST TO CHART: YES OR NO

NAME OF STUDY

Approval Date:

Protocol# VISIT: **Patient Identity** Check box to indicate if sample will be SPECIMEN COLLECTED identified by name or non-name identifier: DATE TIME TO BE TIME ACTUALLY **HID F** PATIENT NAME e.g. Last name, First Name COLLECTED COLLECTED ΑM ΡМ PM NAME: CLIENT CODE DOB: SEX: M/F U# ORDERING PHYSICIAN/ PHYSICIAN # e.g. Study ID #, Initials or PI Name, Initials **PATIENT** STUDY ID# RESEARCHER NAME/PHONE TO CONTACT IF QUESTIONS COLLECTION INSTRUCTIONS: Completed request form and tubes provided by research coordinator. List tubes to be collected: WRITE IN **PROCESSING INSTRUCTIONS** OR ATTACH STUDY SPECIFIC INSTRUCTIONS CODE СТ X TEST: CHECK ALL THAT APPLY Χ **OE** Order Entry Charge **OVP** Venipuncture charge for 1 tube If Fairview lab Staff Collect OVP1 Venipuncture charge for 2-4 tubes If Fairview lab Staff Collect OVP2 Venipuncture charge for 5 or more tubes If Fairview lab Staff Collect oss Processing charge when testing sent out: Centrifuge blood or aliquot urine OSS₁ Processing charge when testing sent out: Centrifuge blood and aliquot urine or centrifuge blood and make smears OSS₂ Processing charge when testing sent out: Centrifuge blood, aliquot urine and make smears OPKG1 Packaging charge **SHIP** Shipping PDI Package Dry Ice WRITE IN SEND OUT INSTRUCTIONS OR ATTACH STUDY SPECIFIC INSTRUCTIONS **HSC**