PATIENT INFORMATION – FOR INVESTIGATIONAL DRUG STUDIES PHARMACY

The Investigational Drug Studies Pharmacy needs the following information on all study patients.

PATIENT'S FULL NAME: (first,middle,last)____

PATIENT'S ADDRESS:

- STREET: ____
- CITY & STATE: ____
- ZIP CODE: ____
- TELEPHONE NUMBER: ____

PATIENT'S SEX: ________ MALE ________ FEMALE

PATIENT'S DATE OF BIRTH (MM/DD/YYYY): __ __/ __ __/ __ __ __ __

PATIENT'S HOSPITAL NUMBER (if one has been assigned): __________________________

ALLERGIES TO MEDICATIONS:

____

____

____

PRIOR ADVERSE REACTIONS TO DRUGS: ________ NONE ________ YES

IF YES – LIST DRUG AND TYPE OF REACTION EXPERIENCED (i.e. nausea, hives, difficulty breathing, etc.) **WE MUST BE GIVEN PRIOR ADVERSE REACTIONS TO DRUG INFORMATION**

____

____

____

Study Name/IDS #: ____

Study Coordinator/Contact Person: ____

Phone Number: ________________

Fax the completed form to the Investigational Drug Studies Pharmacy: 612-273-2176. IDS Pharmacy must have a completed form before any prescriptions can be dispensed.

Please call the Pharmacy, at 612-273-6212, with any questions. Thank You.