



# HARRIS HEALTH SYSTEM RESEARCH PATIENT REGISTRATION FORM

**Instructions:** This form is to be completed by research personnel at the time informed consent is obtained and each time Harris Health resources are utilized for research tests/procedures. Please fax the completed form to 713.440.1207 or scan and email to [Jamie.simple@harrishealth.org](mailto:Jamie.simple@harrishealth.org).

<b><u>CONTACT INFORMATION</u></b> (For research personnel completing the form)			
Name:		Date:	
Phone:	Fax:	Email:	
Location: <input type="checkbox"/> BTGH <input type="checkbox"/> LBJGH <input type="checkbox"/> QM <input type="checkbox"/> Community Health Center/Clinic:			
Affiliation: <input type="checkbox"/> UTHealth <input type="checkbox"/> BCM <input type="checkbox"/> MDACC <input type="checkbox"/> Other: _____			
<b><u>RESEARCH PROTOCOL INFORMATION</u></b>			
IRB Protocol Number:		Principal Investigator:	
<b><u>RESEARCH PATIENT INFORMATION</u></b>			
Patient Name:		Harris Health MRN:	
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Informed Consent:	
<b><u>RESEARCH SERVICES</u></b> (List research tests/procedures performed utilizing Harris Health resources)			
Date of Service:	Test/Procedure:		
Date of Service:	Test/Procedure:		
Date of Service:	Test/Procedure:		
Date of Service:	Test/Procedure:		
Date of Service:	Test/Procedure:		
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Date of Service:	Test/Procedure:		
Date of Service:	Test/Procedure:		
Date of Service:	Test/Procedure:		
<b>PATIENT FINANCIAL SERVICES USE ONLY</b>			
<b>Date Received:</b> _____		<b>Received By:</b> _____	
<b>Date Entered:</b> _____		<b>Entered By:</b> _____	