



*DCOL Center for Clinical Research*

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**STAFF REFERRAL FORM**

Date: \_\_\_\_\_

Name of Referring Party: \_\_\_\_\_

Department: \_\_\_\_\_ Phone/Ext: \_\_\_\_\_

Name of Patient Being Referred: \_\_\_\_\_ Pt's DOB: \_\_\_\_\_

Patient's Phone #: \_\_\_\_\_ Chart #: \_\_\_\_\_

Potential Clinical Trial: \_\_\_\_\_

**FAX TO (903) 238-9934 OR SEND INTEROFFICE MAIL**

**Completed by Research Department**

Research Coordinator: \_\_\_\_\_

Clinical Trial Patient Screened for: \_\_\_\_\_

Did Patient Qualify to Randomize in Study? (Circle one)                      Yes                      No

If "No", state why patient didn't qualify: \_\_\_\_\_

\_\_\_\_\_

Make copy of form and return to Referring Party:

Date Sent: \_\_\_\_\_ To: \_\_\_\_\_

If "Yes" give form to Clinic Supervisor for Gift Card distribution to Referring Party.

Call person referring to notify that their patient qualified and instruct them to come by the Research Center to pick up the Gift Card

Have referring party sign below when Gift Card is collected: Gift Card Selected: \_\_\_\_\_

\_\_\_\_\_  
Referring Party Signature

\_\_\_\_\_  
Date

Clinic Supervisor: Initial and file original in Research Dept: \_\_\_\_\_