



*DCOL Center for Clinical Research*

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*www.DCOLResearch.com*

**DCOL Employee Referral Form**

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

Referring Employee: \_\_\_\_\_

DCOL Department: \_\_\_\_\_ Extension: \_\_\_\_\_

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

Patient's Phone # \_\_\_\_\_ Potential Clinical Trial: \_\_\_\_\_

\*\*\*Please circle \$25 gift card preference: **WAL-MART** **KOHL'S** **TARGET**

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

**To Be Completed by Research Department**

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

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

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

If "No", why did Patient not qualify? \_\_\_\_\_

Date Referring Employee was notified of non-qualify : \_\_\_\_\_

If "Yes", deliver Gift Card to Referring Employee -

\_\_\_\_\_  
Referring Employee's Signature

\_\_\_\_\_  
Date Received

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