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.

CONTACT INFORMATION (For research personnel completing the form)		
Name:		Date:
Phone:	Fax:	Email:
Location: ☐ BTGH ☐ LBJGH ☐ QM ☐ Community Health Center/Clinic:		
Affiliation: ☐ UTHealth ☐ BCM ☐ MDACC ☐ Other: _____		
RESEARCH PROTOCOL INFORMATION		
IRB Protocol Number:	Principal Investigator:	
RESEARCH PATIENT INFORMATION		
Patient Name:	Harris Health MRN:	
Date of Birth:	☐ Male ☐ Female	Date of Informed Consent:
RESEARCH SERVICES (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:	
Date of Service:	Test/Procedure:	
Date of Service:	Test/Procedure:	
Date of Service:	Test/Procedure:	
Date of Service:	Test/Procedure:	
PATIENT FINANCIAL SERVICES USE ONLY		
Date Received: _____	**Received By:** _____	
Date Entered: _____	**Entered By:** _____	