

ICCTG PROTOCOL #1

Patient Transfer Originating Center (Administrative)

Patient ID: _____
 Patient Initials: _____
 Clinical Center: _____
 Contact Week: _____
 Date: ____ / ____ / ____
 month day year
 RC ID: _____

(Research Coordinator completed whenever a patient transfers to another participating site.)

Originating Center (Completed by the Originating Center)

NOTE: Photocopies of this form to be sent to the DCC and the Receiving Center.

1. Indicate date and week number of last patient visit
(at originating center).
 Date: ____ / ____ / ____
 month day year
 Week #: ____

2. Indicate the last week for which study medication
has been dispensed (by originating center).
 Week #: ____

3. Indicate date the patient will run out of study
medication.
 Date: ____ / ____ / ____
 month day year

4. Date and week number of next scheduled visit
(at receiving center).
 Date: ____ / ____ / ____
 month day year
 Week #: ____

5. Date study medication and case report forms
copied and sent to receiving center.
 Date: ____ / ____ / ____
 month day year

6. Please indicate receiving study center I.D. number: _____

7. Date receiving center contacted.
 Date: ____ / ____ / ____
 month day year

8. Name of Research Coordinator contacted at
receiving center.

9. Indicate reason for transfer:

A transfer is considered complete when the receiving center has received all required materials from the originating center (a copy of the patient's study record and any available packets of study medication), and an informed consent is signed at the receiving center.

(Research Coordinator completed whenever a patient transfers to another participating site.)

Receiving Center (Completed by the Receiving Center)

NOTE: Photocopies of this form to be sent to the DCC and the Originating Center.

1. Indicate the date copy of study record was received from originating center:
Date: ____ / ____ / ____
month day year
2. Indicate the date the study medication was received from the originating center.
Date: ____ / ____ / ____
month day year
3. Indicate the date the receiving center was contacted by the patient or the originating center.
Date: ____ / ____ / ____
month day year
4. Indicate date and week number of patient's first scheduled visit (at receiving center).
Date: ____ / ____ / ____
month day year
Week #: ____
5. Date patient signed informed consent:
Date: ____ / ____ / ____
month day year

A transfer is considered complete when the receiving center has received all required materials from the originating center (a copy of the patient's study record and any available packets of study medication), and an informed consent is signed at the receiving center.

6. Date transfer completed: _____ Date: ____ / ____ / ____
month day year
7. Indicate receiving physician I.D. #: _____
8. Comments (optional): _____