

ICCTG

PROTOCOL #1

Patient Contact Information (Administrative)

Patient ID: _____
Patient Initials: _____
Clinical Center: _____
Contact Week: 0
Date: ____ / ____ / ____

month day year

RC ID: _____

(Patient Completed at Baseline 1)

**This form contains confidential information, and is for Clinical Center use *only*.
DO NOT forward to the DCC.**

- | | | | | |
|----|---------------------------------------|--|--|--|
| 1. | Name: | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="display: flex; justify-content: space-between; font-size: 0.8em; margin-top: 5px;"> Last First Middle Initial </div> | | |
| 2. | Address: | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="margin-top: 5px;">Street Address</div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border-bottom: 1px solid black; width: 60%;"></div> <div style="border-bottom: 1px solid black; width: 15%;"></div> <div style="border-bottom: 1px solid black; width: 25%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 0.8em; margin-top: 5px;"> City State Zip Code </div> <div style="margin-top: 10px;">Mailing Address, if different than above:</div> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="margin-top: 5px;">Street Address</div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border-bottom: 1px solid black; width: 60%;"></div> <div style="border-bottom: 1px solid black; width: 15%;"></div> <div style="border-bottom: 1px solid black; width: 25%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 0.8em; margin-top: 5px;"> City State Zip Code </div> | | |
| 3. | Home Phone Number: | <div style="display: flex; align-items: center;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="margin: 0 5px;">-</div> <div style="border-bottom: 1px solid black; width: 40%;"></div> </div> <div style="margin-top: 5px; font-size: 0.8em;">(area code)</div> | | |
| 4. | Work Phone Number: | <div style="display: flex; align-items: center;"> <div style="border-bottom: 1px solid black; width: 30%;"></div> <div style="margin: 0 5px;">-</div> <div style="border-bottom: 1px solid black; width: 30%;"></div> </div> <div style="margin-top: 5px; font-size: 0.8em;">(area code)</div> | | |
| 5. | FAX Number: | <div style="display: flex; align-items: center;"> <div style="border-bottom: 1px solid black; width: 30%;"></div> <div style="margin: 0 5px;">-</div> <div style="border-bottom: 1px solid black; width: 30%;"></div> </div> <div style="margin-top: 5px; font-size: 0.8em;">(area code)</div> | | |
| 6. | Email Address: | <div style="border-bottom: 1px solid black; width: 100%;"></div> | | |
| 7. | What is the best way to contact you? | <div style="border-bottom: 1px solid black; width: 100%; height: 20px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; width: 100%; height: 20px;"></div> | | |
| 8. | When is the best time to contact you? | | | |

CONFIDENTIAL

Patient Contact
Information
(Administrative)

Patient ID: _____

Contact Week: 0

9. Who is your usual doctor or primary care physician?

Name:

Last

First

Middle Initial

Address:

Street Address

City

State

Zip Code

Phone Number:

(area code)

-

Other Contacts (people at a different address we can contact if we are unable to reach you)

10. Name:

Last

First

Middle Initial

Address:

Street Address

City

State

Zip Code

Phone Number:

(area code)

-

Relationship to you: _____

11. Name:

Last

First

Middle Initial

Address:

Street Address

City

State

Zip Code

Phone Number:

(area code)

-

Relationship to you: _____

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