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.

I C C T G ICCTG PROTOCOL #1	Patient Transfer *Receiving* 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.)

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): _____

_____

_____