ICDB

Interstitial Cystitis Data Base

Patient ID: ___ ___ ___ ___ ___ ___

Date: ___ ___ / ___ ___ / ___ ___
month day year

Future Contact Information

Has the patient agreed to release the information below to the ICDB Study Data Coordinating Center for inclusion in a central list of ICDB Study participants?

☐$_1$ Yes *Complete the Contact Information section below.*

☐$_0$ No *Patient refused to sign the revised Informed Consent and/or declined participation in the participant list.* ***Please stop here.***

Contact Information

Please PRINT all information clearly.

Patient Name: _____ ____ _____
First Name *MI* *Last Name*

Address: _____
Street Address 1

_____
Street Address 2

_____ __ __ ___ ___ ___ ___ ___
City *State* *Zip*

Home Phone Number: (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

CONTACT