Modification of Diet in Renal Disease Study

TRANSFER FORM

This form is to be completed by the Study Coordinator whenever a patient transfers from another Clinical Center's care. The destination Center should complete this form.

Contact the original Clinical Center to coordinate date of transfer and other pertinent patient information.

QUESTION #	INSTRUCTIONS
1.-3.	Identify the patient by the new sequential identification number and name code.

For DCC Use Only
Rev. 1 9/1/88

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MDRD

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FORM # 3 0

1. New Patient Identification Number ..... ___ ___ ___ ___ ___ ___
2. New Patient Name Code ..... ___ ___ ___ ___
3. Clinical Center (**destination**) ..... ___ ___
4. Clinical Center (**original**) ..... ___ ___
5. Original Patient Identification Number ..... ___ ___ ___ ___ ___ ___
6. Date of transfer ..... ___ ___/___ ___/___ ___

101. Date this form completed ..... ___ ___/___ ___/___ ___
102. Certification number of person filling out this form ..... ___ ___ ___ ___ ___
103. Date form entered ..... ___ ___/___ ___/___ ___
104. Certification number of data entry person ..... ___ ___ ___ ___ ___

Retain a copy of this form for your files. Send the original to the MDRD Study Data Coordinating Center. Please use MDRD Study mailing labels:

MDRD Study Data Coordinating Center
Department of Biostatistics & Epidemiology
The Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44195-5196

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