|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Research Registration Form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Return this form to Research Operations on or before the date of service. Please print clearly. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Instructions**  **Complete and submit this form when a research participant is scheduled at an Allina facility and meets one or more of the following criteria** *(mark all that apply*): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Research site must review the bill because services may be paid for by study | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The participant has insurance from Medicare, Medicare Replacement, Medicaid, or research should check coverage to ensure it is not a government payer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A study medical device was/will be used or replaced on this date of service | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treatment for complication directly related to the study drug, device, or intervention  (Medicare, Medicare Replacement, or Medicaid only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Research Participant Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Privacy Note:All information is confidential and will be handled according to HIPAA regulations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | Enter First MI Last | | | | | | | | | | | | | | | | | | | | | | | | | | | DOB: | | | | enter a date. | | | | |
| New study patients: Enterprise ID (MRN): | | | | | | | | | | | | | | Enter MRN here | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Research Service Information *(mark all that apply)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Service: | | | | | | Click here to enter a date. | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | |
| Patient Class: | | | | | | Outpatient | | | | | | Inpatient | | | | | | | | Allina Physician Visit | | | | | | | | | | | | | Other, Clinic Visit | | | |
| Allina Facility: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abbott Northwestern | | | | | | | | | Buffalo | | | | | | | Mercy | | | | | Mercy – Unity | | | | | | | | St. Francis | | | | | United |  | |
| Other Allina Facility (please name): | | | | | | | | | | | | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | |  | |
| Study Visit Type (optional): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Labs | | | Imaging/Diagnostics | | | | | | | | | | | | | | Other/Visit #: | | | | | | | | | Click here to enter text. | | | | | | | | |  | |
|  | | | | |  | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical Device Information (*device study only*)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Complete this section only if a research medical device was or will be used during this date of service. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Device Name: | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | |  | | Loc: OR Cath Lab IR CV-OR | | | | | | | | | | | |
| Physician Name: | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | |  | Other: | | | | | | Click here to enter text. | | | | | |
| Device Type: | | | | IDE  HDE/HUD PMA Approved  Replacement  Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FDA Assigned # (IDE and PMA only): | | | | | | | | | | | | | | | Click here to enter text. | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Research Site, Study, and Contact Information (all fields required)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Research Site Name: | | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Study Short Name or Protocol #: | | | | | | | | | | | | | enter short study name | | | | | | | | | | | | | | | | | | | | | | | |
| eProtocol ID #: | | | | | | | | | | | Enter eProtocolID | | | | | | | | | | | | | | | | | | | |
| Enter contact name | | | | | | | | | | | | | | | | | | | | | | Enter contact phone | | | | | | | | | | | | | | |
| Contact Name | | | | | | | | | | | | | | | | | | | | | | Contact Phone | | | | | | | | | | | | | | |

Send to Research Operations by:

Fax: 612-262-4953 *(or)* Email attachment (**send HIPAA secure**): **spa@allina.com**