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|  | **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  |
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|  |
| **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. |  |
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| **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**