CLINICAL RESEARCH
O. R. CASES

STUDY COORDINATORS:

PLEASE MAKE SURE YOU BRING THIS FORM WITH YOU WHEN REGISTERING OR BOOKING A PATIENT FOR A CASE THAT WILL REQUIRE A PROCEDURE TO BE DONE IN THE OR DEPT.

THIS WILL INSURE THE CHARGES ARE BILLED TO THE APPROPRIATE STUDY.

ALL O.R. STUDY CASES MUST BE BOOKED AS A SURGICAL DAY CARE IN MEDITECH

Study Name: _D.________________________ Study Billing Number: _85000__________________

Study Contact Name: ___________________________ Contact Phone Number____________________

Patient Name: ______________________________ Medical Record #___________________

DOB: __________________________ Patient SS#______________________ SEX: M **F**

Date of Service: ____/______/______ Referring Doctor: ______________________________

Procedure being ordered: ____

BILLING INFORMATION

Who should receive this bill:

Name :____

Address____

City State Zip Code

Comments____

____

MTF 7/11