

**RESERVATION FORM PART-B
RESEARCH/CLINICAL TRIALS ONLY**

SEND TO: ADMITTING, FAX: 353-3925, BOX 0208, ATTN: JULIE CANTU

STUDY BILLING CONTACT: _____ **BOX:** _____ **TEL#:** _____

BILLING CONTACT: BRENDA CLARK, BOX: 0810, 353-3702

Patient Name: _____ **zzMR#** _____ **zzVisit#** _____

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|---|-------------------------------|-----------------------------|--|
| 1. Will the patient's inpatient stay be extended due to the research study?
If yes, How many additional days will the stay be lengthened? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| | Days <input type="checkbox"/> | | |
| 2. Will any additional OR procedures be performed for the research study in addition to those for the patient's treatment?
If yes, Please specify: _____
_____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 3. Will any additional time be required in the OR due to the research study?
If yes, Please estimate the required amount of additional time:

_____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 4. Will any additional anesthesia services be required for the research study in addition to those for the patient's treatment?
If yes, Please specify which services:

_____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 6. Will any additional PACU services be required for the research study in addition to those for the patient's treatment?
If yes, Please specify which services:

_____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 7. Will any additional pharmacy items be required for the research study in addition to those for the patient's treatment?
If yes, Please specify which services:

_____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 8. Will any additional supplies be required for the study in addition to those for the patient's treatment?
If yes, Please specify which supplies:

_____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 9. Are any other inpatient procedure or services not listed above required by the clinical study in addition to the patient's normal treatment?
If so, Please specify below:

_____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

Reminder: Please direct any ancillary tests or procedures for the research study to the study zzMRN and zzVisit number by affixing completed labels to the order form.