


Public reporting burden for this collection of information is estimated to vary from 5 to 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0624). Do not return the completed form to this address.

Filling out PDF Forms

This PDF form contains “**roll-over** or **double-click** ” help functionality.

This form allows you to enter data directly onto the screen. After completing the form, you are able to print the document so that you can fax/mail the document.

To fill out a form:

1. Select the hand tool. 
2. Position the pointer inside a field, and click to type text.
3. After entering text or selecting a check box, do one of the following:
 - Press tab to accept the form field change and go to the next form field.
 - Press Shift+Tab to accept the form field change and go to the previous form field.
 - Press Enter (Windows) or Return (Mac OS) to accept the form field change and deselect the current form field.
4. Once completed, print the form.

Request for Patient Transfer (For studies in OPEN and on the CTSU menu; SWOG sites must use the SWOG online system for SWOG studies; all sites must use the GOG system for GOG studies.)

Date of Request: _____ Requested Effective Date of Transfer: _____
 MM/DD/YY MM/DD/YY

Patient ID#: _____ Group/Protocol Number: _____

Case Status: Active Trt F/up Is the transfer occurring between registration steps? Yes/No

Transferring Site/Investigator* Information: (Please submit the form to receiving site (if applicable) after completion of this section.)

Site Name: _____ CTEP Code: _____

Treating Investigator Name: _____ CTEP IID#: _____

Treating Investigator Signature: _____

Receiving Site/Investigator* Information:

Site Name: _____ CTEP Code: _____

Credited Cooperative Group (For follow-up credit):

Treating Investigator Name: _____ CTEP IID#: _____

Treating Investigator Signature: _____

By signing this form the receiving site takes responsibility for **all outstanding data from the originating site. Please review the Transfer checklist.*

**Completion of this form is required for transfers between investigators located at the same site.*

Level of responsibility being transferred to receiving site or investigator:

- Full: (All responsibility for the patient is transferred to receiving institution)
- Partial: (Temporary transfer of subject to another site; please indicate the level of responsibility at the receiving site)

Data Share: (For transfers for studies in Rave, if supported by the LPO; sites may elect to share data. Indicate length of time required for data sharing.) _____

Contact Person: _____

Phone #: _____ Email Address: _____

Complete this form and submit to the CTSU Operations Center by e-mail at ctscontact@westat.com or by fax to 1-888-691-8039. For more information, contact the CTSU Help Desk at 1-888-823-5923 or CTSUContact@westat.com.

Requests will be reviewed within 3 business days of receipt.	
Office Use Only:	
Receiving site approved for registration: Date: _____ Int. _____	Receiving Investigator eligible: Date: _____ Int. _____
LPO Authorization: _____	PMB Copied: dt__ Int. ____