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.

CANCER TRIALS SUPPORT UNIT

PATIENT ENROLLMENT TRANSMITTAL FORM

> CTSU patient enrollment hours are 9:00 am – 5:30 pm ET – Mon.-Fri. *(Prior to enrollment, please refer to the enrollment documents on the CTSU web site as some protocols have limited enrollment hours. Enrollments received after 5:00 pm will be processed the next day unless the CTSU registrar is notified via the emergency number of a time of need enrollment.)*
> To enroll a patient:
> 1) Complete this cover sheet
> 2) Call 1-888-462-3009 and notify CTSU Patient Registrar of incoming enrollment.
> 3) Fax cover sheet along with any other protocol-specific forms due at enrollment to the CTSU Patient Registrar at 1-888-691-8039. *For Emergencies call 301-704-2376

1. Date*:(MM/DD/YYYY)* _____ / _____ / _20_____   Enrollment Cover sheet plus (   ) page(s)

2. Patient is to be enrolled on: _____
   Cooperative Group Name and Protocol Number

3. Enrollment Contact Person:_____Phone: _____
   First name   Last name
   Fax: _____   E-mail: _____

4. Treating Institution: _____
   Name   *City*   *State*

5. Treating Institution's NCI code:

6. Treating Physician: _____ CTEP ID: _____
   First name   Last name

7. Indicate Cooperative Group affiliation to receive enrollment credit: _____
   Cooperative Group name

8. Date patient signed IRB-approved consent form: *(MM/DD/YYY)* Date:_____ / _____ / 20_____

9. Date of HIPAA authorization signed for release of PHI to the CTSU and the protocol lead group?

   Date signed *(MM/DD/YYYY)* _____   ☐Exempt *(non-USA participant/small business)*

10. Has patient ever been enrolled on any other Cooperative Group trial?   ☐Y   ☐N

    If yes, provide Group name and Protocol number _____

11. Provide any specimen tracking ID or ancillary study ID that has previously been assigned to this subject for this trial or a related ancillary study. _____ID _____ ID Source

---

ADDITIONAL INFORMATION (Optional)
For expedited shipping please provide your Federal Express Account Name and Number*.

Account Number: _____

*Available for selected protocols as outlined in the drug shipment information in the protocol. This information must be completed for each patient enrollment where expedited drug shipment is available.

To be completed by the CTSU Registrar:
Patient ID: _____ Enrollment Date: _____ Treatment Arm_____