OMB# 0925-xxxx
Expiration Date xx/xx/xxxx

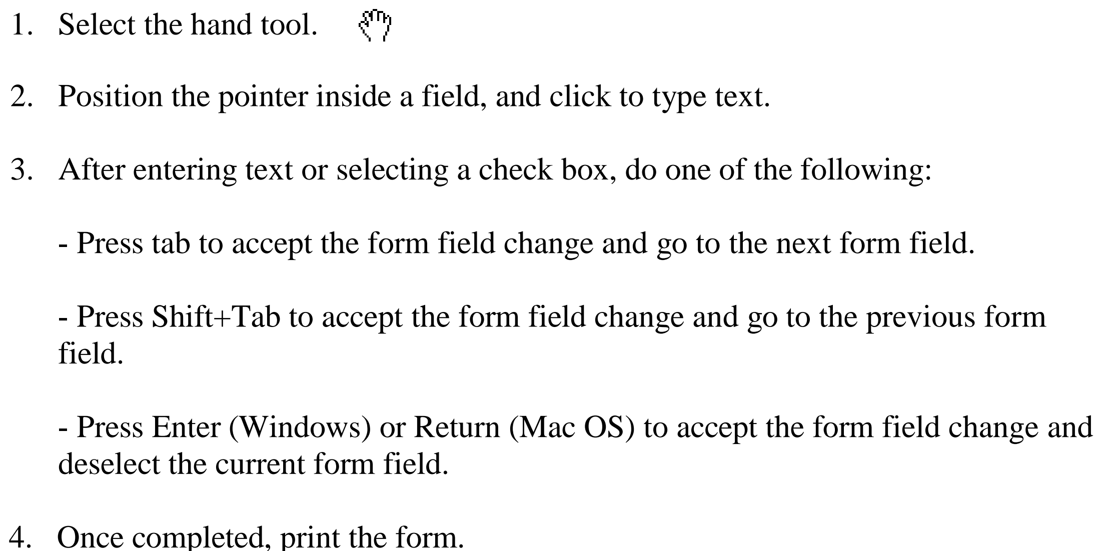
Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency 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-xxxx). 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.

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CANCER TRIALS SUPPORT UNIT

PATIENT ENROLLMENT TRANSMITTAL FORM

CTSU patient enrollment hours are 9:00 am – 5:30 pm ET – Mon.-Fri.
To enroll a patient:
1) Complete this cover sheet
2) Call the CTSU Help Desk about the incoming enrollment. (1-888-823-5923 or ctsucontact@westat.com)
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 the CTSU Help Desk)

1. Date:*(MM/DD/YYYY)* ______/_______/ _20______ Enrollment Cover sheet plus (

2. Patient is to be enrolled on: ____
Lead Organization 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 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)*

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*____________

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