



COA RESEARCH PRE-REGISTRATION FORM (post-Epic)

Identify research outpatient visit or inpatient stay prior to the clinic registration or admission.

RC
Submission Date: _____ Name: _____ RC
Phone: _____

Patient Name: _____ Physician: _____

Date of Service: _____ Medical Record number: _____

IRB number: _____ Is this an inpatient stay? Yes No

Clinic Location: _____ Will patient be registered here? Yes No

Will patient register in
Referred Testing? Yes No Is this a blood draw? Yes No

Does this include standard
of care procedures? Yes No If yes, provide Insurance Payor: _____

List each COA medical procedure from the study for this visit or inpatient stay:

NON-COA CLINICAL BILLABLES THAT MAY GENERATE A SEPARATE BILL

Billed by Pediatrics' Business Svcs (for HSF)

Please mark YES if this visit includes :

- Professional read/interpretation of tests by a DOP faculty member e.g. EEG, ECG, EMG, flow cytometry, blood gas, etc.
- Simon Sedation service
- Add other _____

YES?

Billing of labs / procedures of the UAB Health System will require OnCore. Questions? Contact Melissa McBrayer, UAB Pediatric Research Office.

Billed by Pediatric and Congenital Cardiology

Please mark if this visit includes research echocardiography.

Billed by Non UAB and Non COA entities

Alabama Ophthalmology Associates Pediatric

Anesthesia Associates, PC

Pediatric ENT Associates

Pediatric Radiology Associates, PC (MRI, x-ray, bone scan, CT scan, ultrasound read fees)

See ***Table of Contacts for Clinical Research Prices** to ensure appropriate billing.

When complete, send this page by email to ALL of the following:

nharig@wgrcm.com; pryan@wgrcm.com; rgunn@wgrcm.com; blucia@wgrcm.com; sholland@uabmc.edu; hayleepate@uabmc.edu; Pam.Barlow@childrensal.org; pro@uabmc.edu; kristalhock@uabmc.edu

*Table of Contacts is found under **Financial Information, Forms and Budgets** on www.uab.edu/peds/pro.