DATE: ____________________________
TO: CUMC Research Pharmacy – Black Building, B-30
FAX: # 212-305-0068
FROM: ____________________________
CONTACT # ________________________
IRB# ____________________________

- Patient Name: __________________________________________
- Patient Medical Record Number: _________________________
- Patient Study ID Number: ________________________________
- Patient's Weight (if used for dosing): _____________________ kg
- Patient Height (if applicable): ____________________________ cm
- Patient BSA (if applicable): _____________________________ m²

In addition to this FAX Cover, the following are being faxed to the Research Pharmacy (check):

☐ Signature page of Informed Consent Form (required at enrollment)
☐ A complete Official NYS Prescription
☐ Randomization Confirmation
☐ A Complete NYPH Inpatient Order Form
☐ A complete NYPH Adult Outpatient Infusion Order Form
☐ Other: _______________________________________________

Please fax prescriptions at least 24 - 48 hours in advance.