FAX TO CUMC RESEARCH PHARMACY

DATE: __________________________

TO: CUMC Research Pharmacy – IP-749

FAX: # 212-305-0397

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.