

Patient Name:

Date of birth:

Medical Record #:

**HISTORY/PHYSICAL/
 PROGRESS NOTES**

Subject Screening #:

ADDRESSOGRAPH

DATE							
	Consent Conference						
	A Consent conference was held for protocol IRB# _____ (<i>Study Title</i>)						
	During this consent conference the consent (version date _____) and the HIPAA						
	authorization were read. Study visit schedules were also reviewed in detail.						
	The subject did <input type="checkbox"/> or did not <input type="checkbox"/> have any questions. If the subject had questions they						
	did <input type="checkbox"/> or did not <input type="checkbox"/> N/A <input type="checkbox"/> acknowledge satisfaction with the answers. After answering any						
	questions, the subject decided: to <input type="checkbox"/> not to <input type="checkbox"/> sign the consent form and HIPAA authorization. A						
	signed copy of the consent & HIPAA form was given to the subject to keep for their records. The original						
	consent form and HIPAA authorization will be placed in the research study chart.						
	Future appointments will be scheduled at a later date. The subject was encouraged to contact any						
	of the research staff or those listed on the consent should they have any questions or concerns. Should						
	you have any questions please contact the (<i>Name of Office</i>) at (<i>phone #</i>) or the clinic at (<i>phone #</i>)						
	or Dr. _____ via pager at _____.						
	Consent obtained prior to any study related procedures being performed. Yes <input type="checkbox"/> No <input type="checkbox"/>						
	Time Consent Signed: _____						
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Clinical Research Associate</td> <td style="text-align: center;">Physician</td> </tr> <tr> <td style="text-align: center;">Date</td> <td style="text-align: center;">Date</td> </tr> </table>	_____	_____	Clinical Research Associate	Physician	Date	Date
_____	_____						
Clinical Research Associate	Physician						
Date	Date						

