HARRIS HEALTH SYSTEM
RESEARCH PATIENT REGISTRATION FORM

Instructions: This form is to be completed by research personnel ***at the time informed consent is obtained and as soon as possible after utilizing Harris Health resources*** for research tests/procedures. Please email the completed form to pfsresearchbillingnotification@harrishealth.org.

CONTACT INFORMATION (For research personnel completing the form)		
Name:		Date:
Phone:	Fax:	Email:
Location: ☐ BTGH ☐ LBJGH ☐ QM ☐ Community Health Center/Clinic:		
Affiliation: ☐ UTHealth ☐ BCM ☐ MDACC ☐ Other: _____		
RESEARCH PROTOCOL INFORMATION		
IRB Protocol Number:		Principal Investigator:
RESEARCH PATIENT INFORMATION		
Patient Name:		Harris Health MRN:
Date of Birth:	☐ Male ☐ Female	Date of Informed Consent:

RESEARCH SERVICES (List research tests/procedures performed utilizing Harris Health resources; submit ***without delay*** after the date of service)	
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:
Date of Service:	Test/Procedure:

PATIENT FINANCIAL SERVICES USE ONLY

Date Received: _____ **Received By:** _____

Date Entered: _____ **Entered By:** _____