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***):** _____**m^2**

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.