



MRC 0299 06 2006

Centre universitaire de santé McGill
McGill University Health Centre

*Les meilleurs soins pour la vie
The Best Care for Life*

HME MCH HGM MGH HRV RVH HNM MNH ITM MCI

Name: _____

Health Record Number: _____

Date of Birth: _____

or ADDRESSOGRAPH _____

Confirmation of Participation in Research

To: **Medical Records Services**

Investigator: _____ (fillable field)

Study Title: _____

MUHC or McGill Study Number:	_____ (fillable field)
Expected Enrollment Start Date:	_____ (fillable field)
Expected Enrollment End Date:	_____ (fillable field)

Study Intervention/Treatment: Indicate treatment, dose, frequency (i.e. Adriamycin 60 mg/m² Q 2 weeks)

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Potential Side Effects or Drug Interactions: see attached Informed Consent Form

Staff to Contact for Further Information: (print names):

Principal Investigator: _____ (fillable field) ext: _____

Attending Physician: _____ (fillable field) ext: _____

Study Coordinator _____ (fillable field) ext: _____

***** In Case of Emergency Call ****** _____ (fillable field)

Telephone or Pager Number: _____ (fillable field)

Signature : _____ Date : _____

YYYY / MM / DD