



# UNIVERSITY HEALTH SYSTEM

## Investigational Drug Information Form

Patient Enrollment Date:  
Estimated Completion Date:

**THIS FORM MUST BE COMPLETELY FILLED OUT AND A COPY MUST BE PLACED IN A CONSPICUOUS SECTION OF THE INPATIENT AND OUTPATIENT MEDICAL RECORD OF EACH PATIENT ENROLLED IN THE STUDY**

Protocol Title:

Investigator:	Office Phone:	Pager Number:	Home Phone:
Study Coordinator/Assistant:	Pager:	Other Emergency Contact:	Pager:

Authorized Prescribers:

Study Duration: From                      To	Expected Total Enrollment: Out-Pt   In-Pt
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**CAUTION: BEFORE PRESCRIBING NEW MEDICATIONS OR CHANGING CURRENT DOSING, PLEASE CONTACT THE INVESTIGATOR OR OTHER MEMBER OF THE RESEARCH TEAM!**

Generic Name:	Synonym/Trade Name:
IND Number:	Therapeutic Classification:
Is the study drug FDA approved? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is study drug being used off label? Yes <input type="checkbox"/> No <input type="checkbox"/>
Dosage Form/Strength:	Indications for Use:
Usual Dosage Range:	Administration Rate:
Administration Route:	Administration Devices:
Storage Temperature: Before Mixing (C) <input type="checkbox"/> (F) <input type="checkbox"/> After Mixing (C) <input type="checkbox"/> (F) <input type="checkbox"/>	Protect from Light? Before Mixing Yes <input type="checkbox"/> No <input type="checkbox"/> After Mixing Yes <input type="checkbox"/> No <input type="checkbox"/>

Filter Required during administration?: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, filter size 0.2 micron <input type="checkbox"/> Other <input type="checkbox"/>	Stability After Mixing (if known): Expires in <input type="checkbox"/> hours      Unknown <input type="checkbox"/>	
Is the study placebo controlled? Yes <input type="checkbox"/> No <input type="checkbox"/>	Source of additional drug supply (if any): Name: _____ Phone: _____	
Is the study blinded? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please provide the following information → → → →	Unblinded Investigator Name: _____ Phone: _____	
Solution Preparation Instructions:		
Description of pharmacological mechanism of action of drug:		
Drug administered by (check all that apply): M.D. <input type="checkbox"/> Study Nurse <input type="checkbox"/> Unit Nurse <input type="checkbox"/>		
Side Effects (in order of incidence):	Appropriate Response:	
Adverse Reactions:	Appropriate Response: (Immediately contact the Investigator or member of the Research Team)	
Toxicities:	Appropriate Response:	
Antidotes (if any): Dosage/Route:	Special Precautions:	
<p style="text-align: center;">NURSING STAFF ONLY: Please sign and date below (or electronically sign and date on emtek)          indicating you have reviewed the above information prior to using the investigational drug.</p>		