Clinical Research Screening Referral: Oncology

The James Cancer Network
The Ohio State University Wexner Medical Center

Is this also a referral? ☐ YES ☐ NO (if yes, please include patient demographics)
Please fill out this form with as much information that is available.
Include a demographic/information for the patient

Email completed form and demographic sheet to: cancertrials@osumc.edu or you may fax this information to 614-293-7151.

Patient Contact Information (please attach patient demographic or face sheet)

Last Name: Click here to enter text.

First Name: Click here to enter text. | **Middle Initial:** Click here to enter text.

Phone Number: Click here to enter text. ☐ Home ☐ Cell/Mobile

Clinical Information for Research Screening

Diagnosis: Click here to enter text.

Stage: Click here to enter text.

Brain metastasis? ☐ No ☐ Yes If yes, stable for 3 months? ☐ Yes ☐ No

Date of last biopsy Click here to enter text. **Is tissue available?** ☐ Yes ☐ No

Results of genomic testing if available: Click here to enter text.

What is the goal for the clinical trial referral? Click here to enter text.

Past cancer treatment history (enter general below – no need to enter dates of treatment)

Chemotherapy: Click here to enter text.

Radiation Therapy: Click here to enter text.

Surgery: Click here to enter text.

Bone Marrow/CAR-T: Click here to enter text.

Other Co-morbid illnesses: (check all that apply)

☐ Auto immune disease	☐ Uncontrolled diabetes	☐ Active infection
☐ DVT/PE	☐ Low ejection fraction	☐ High QT
☐ Hepatitis	☐ HIV	☐

☐ Other (describe) Click here to enter text.

Referring Provider: Contact Information

Physician Name: Click here to enter text.

E-mail: Click here to enter text. | Phone Number: Click here to enter text.

Note: Clinical Research coordinator will directly contact the referring provider regarding recommendations.