**Research project title:**

**Chief Investigator:**

|  |  |
| --- | --- |
| **Patient name:** |  |
| **CHI number:** |  |
| **Date of birth:** |  |
| **Participant ID number:** |  |
| **Ward/Clinic** |  |

**Please supply the following for use in the above research project:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug** | **Dose** | **Frequency** | **Pack ID****(if applicable)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| **Prescriber’s signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Prescriber’s name printed:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Ext./bleep:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please fax prescription to ARI Clinical Trials Pharmacy – Fax No. 01224 551061**

***PHARMACY USE ONLY***

|  |  |
| --- | --- |
| **Batch number:** |  |
| **Expiry date:** |  |
| **Pharmacist check:** |  |
| **Dispensed by:** |  |
| **Checked by:** |  |
| **Date:** |  |
| **Collected by:** |  |