



## Site Referral Form

Practice Demographics					
Organization / Institution Name:					
Street Address:					
City:		State:		Zip:	
Main Phone:		Main Fax:			
Practice Type (check all that apply):					
<input type="checkbox"/> Private Practice	<input type="checkbox"/> Single Specialty	<input type="checkbox"/> University	<input type="checkbox"/> Hospital		
<input type="checkbox"/> Group Practice	<input type="checkbox"/> Multi-specialty	<input type="checkbox"/> Clinic	<input type="checkbox"/> Other: _____		
Are you currently affiliated with any research networks? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify: _____			Are you a member of ION? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, are you an LPP practice? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Number of Oncology Physicians participating in research:			Number of "New" patients seen each year:		
Number of locations to be opened to Veeda Oncology			If more than one location will be open how is oversight provided for these satellite(s)?		

Research Demographics	
Does site have an established clinical research program? Yes <input type="checkbox"/> No <input type="checkbox"/>	Years in existence:
Does site have an experienced full-time CRC? Yes <input type="checkbox"/> No <input type="checkbox"/> If not full-time, what percentage of time is dedicated to research?	Does site have any additional research staff? Yes <input type="checkbox"/> No <input type="checkbox"/> Please specify:
Does site have a biosafety cabinet for chemotherapy preparation and a chemotherapy infusion area? Yes <input type="checkbox"/> No <input type="checkbox"/>	Does site have a refrigerator dedicated to drug/and lab specimen storage only? Yes <input type="checkbox"/> No <input type="checkbox"/> Dedicated freezer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Can site utilize Central IRB? Yes <input type="checkbox"/> No <input type="checkbox"/> If not, will local IRB grant a waiver?	Does site have space dedicated to research with access to computer (including email access), fax, copier and commercial delivery service Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Clinical Research Experience</b>	
CRC Research Experience _____ years	Lead Principal Investigator Research Experience _____ years
Have any of the site's physicians been the lead PI on an Investigator Initiated Trials?	Yes <input type="checkbox"/> No <input type="checkbox"/>
How many patients did site enroll on clinical trials last year?	
How many patients have they enrolled year-to-date?	

<b>Trial Participation:</b>	
<input type="checkbox"/> Pharmaceutical / Sponsor-Generated Trials # _____	<input type="checkbox"/> Investigator-Initiated Trials # _____
<input type="checkbox"/> Treatment # _____ <input type="checkbox"/> Supportive Care # _____	
<input type="checkbox"/> Cooperative / Group Trials # _____	<input type="checkbox"/> Compassionate Use Trials # _____
<input type="checkbox"/> Data Collection / Retrospective Trials # _____	<input type="checkbox"/> Other: # _____

<b>Contacts:</b>
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**Principal Physician Contact for Clinical Research**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Office Phone: (\_\_\_\_) \_\_\_\_\_ Office Fax: (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

**Clinical Research Contact (Primary Clinical Research Coordinator [CRC])**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Title: \_\_\_\_\_  
Office Address:  Same as Practice Main Address \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Office Phone: (\_\_\_\_) \_\_\_\_\_ Office Fax: (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

**Practice Administrator**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Office Phone: (\_\_\_\_) \_\_\_\_\_ Office Fax: (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

\_\_\_\_\_  
Person Submitting Referral Date

**Please email this referral form to Penny Nadolny at [penny.nadolny@veedaoncology.com](mailto:penny.nadolny@veedaoncology.com) or fax it to her at +1 480-306-4153.**