**Participant information:**

Subject Legal Name: Click or tap here to enter text. Height (in): Click or tap here to enter text.

Biological Sex:[ ] Male [ ] Female Weight (lbs): Click or tap here to enter text.

Gender: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Age (yrs): Click or tap here to enter text.

Medical Record #: Click or tap here to enter text.

**Participant Contact information:**

Telephone (W): Click or tap here to enter text. (H): Click or tap here to enter text. (C):Click or tap here to enter text.

Email address: Click or tap here to enter text.

Preferred method of contact for participant (select only 1): Phone: [ ] W[ ]  H [ ] C or [ ] Email

**Protocol Information**

**Protocol Title:**

Principal Investigator:

IRB Protocol Number:

IRB Expiration date:

Informed Consent signed by subject: [ ]  Yes [ ] No

**Study Purpose**

**The purpose of this study is to:** Click or tap here to enter text.

**Patient Medical Information**

Diagnosis/Past Medical History: Click or tap here to enter text.

Allergies: Click or tap here to enter text.

List of non-study medications taken at home: Click or tap here to enter text.

**Visit Type (Select 1):** [ ] **Inpatient** [ ] **Outpatient**

**Study Visit**

Visit number: Click or tap here to enter text.

Visit Location: [ ] Tower 9A [ ] Tower [ ] 9B [ ] ACC [ ] CTH [ ] CTC

**Diet Order**

**Protocol Specific Metabolic Diet Parameters:** Click or tap here to enter text.

**Nutrition Instructions/Dates on diet:**

***EXAMPLE: Subject will receive 5 days of low salt diet prior to admission. The subject will pick up the diet on 5/16/2019 and will be on the diet from 5/17/2019-5/21/2019.***

|  |  |  |
| --- | --- | --- |
| **Day** | **Date** | **Intervention** |
| Thursday | 5/16/2019 | Participant picks up food |
| Friday | 5/17/2019 | Day 1 Low salt meals |
| Saturday | 5/18/2019 | Day 2 Low salt meals |
| Sunday | 5/19/2019 | Day 3 Low salt meals |
| Monday | 5/20/2019 | Day 4 Low salt meals |
| Tuesday | 5/21/2019 | Day 5 Low salt meals |

MD Signature: Date:

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Contact information**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **NAME** | **EXTENSION** | **PAGER or Cell phone** |
| Primary Contact: |  |  | Page: mobile: |
| Secondary Contact: |  |  | Page:mobile:  |
| Study Coordinator Contact(s): |  |  | Page: mobile:  |