C-health Research (a division of C-health)
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C·health Research
Innovations in Clinical Trials, Diagnostics and Care Delivery

RESEARCH REQUISITION FORM

PATIENT INFORMATION *(attach patient label)*

Patient Name: ☐ M ☐ F
ULI: DOB:
Address: Postal Code:
City, Province: Home phone:

CONFIDENTIALITY: Your information will be kept confidential. By signing this form, you are giving your consent for C-health Research to keep your contact/medical information in a secure database within C-health Research. This allows C-health Research to contact you in the future to discuss research opportunities.

I give permission to be contacted for future research studies ☐**Yes** ☐ **No**

Patient Name:

Patient Signature: ________________________________

Date:

I have been previously diagnosed with (please check all that apply):

☐Type 1 diabetes ☐Type 2 diabetes ☐ Overweight or Obesity ☐ Kidney disease

☐ High Cholesterol ☐Heart Failure ☐ Coronary Artery Disease ☐ Atherosclerosis

☐Other:

Additional Medical History or Notes: