Complications of Age-related Macular Degeneration Prevention Trial
TRANSFER OF PATIENT FORM

NOTE: This form should be used to transfer a CAPT patient from one clinic to another clinic or from one clinic site to another clinic site. Section A must be completed by the Clinic Coordinator and signed by the Ophthalmologist at the clinic/site that the patient is being transferred from. Section B must be completed by the Clinic Coordinator and signed by the Ophthalmologist at the clinic/site that the patient is being transferred to. ***Both clinics/sites involved must agree to the transfer.*** *Please mail or fax the completed form to the Coordinating Center Data Coordinator.*

Section A. Completed by Clinic Coordinator at clinic/site patient transferred from

Clinic Number: __ __ Site Number: ___ Clinic Name: ______________________________

Patient ID: ___ ___ - ___ ___ ___ - C Name Code: ___ ___ ___ ___ ___

Date transfer is effective: ___ ___ - ___ ___ - ___ ___ (mm dd yy)

I agree to transfer a copy of the CAPT documentation to the clinic accepting the patient:

______________________________ / __ __ __ __ / ___ ___ - ___ ___ - ___ ___
Clinic Coordinator Signature Cert # mm dd yy

I agree to the transfer of this CAPT Patient:

______________________________ / __ __ __ __ / ___ ___ - ___ ___ - ___ ___
Ophthalmologist Signature Cert # mm dd yy

Comments: ______________________________

Section B. Completed by Clinic Coordinator at clinic/site patient transferred to

Clinic Number: __ __ Site Number: ___ Clinic Name: ______________________________

I agree to accept this CAPT patient and will follow CAPT procedures in the care of this patient:

______________________________ / __ __ __ __ / ___ ___ - ___ ___ - ___ ___
Clinic Coordinator Signature Cert # mm dd yy

I agree to accept this CAPT patient and will follow CAPT procedures in the care of this patient:

______________________________ / __ __ __ __ / ___ ___ - ___ ___ - ___ ___
Ophthalmologist Signature Cert # mm dd yy

Comments: ______________________________

Coordinating Center Use Only

Date form received/completed: ___ ___ - ___ ___ - ___ ___ Received by: ___________

____ Copy sent to Reading Center Data Coordinator

____ Copy to Systems Analyst Date of CAPT master update: ___ ___ - ___ ___ - ___ ___ Updated by: ______________

____ File Original in Patient File Comments: ______________________________