ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY AUTHORIZATION FORM

Form Completion Instructions:

These forms (#18, 18A) are completed by the CCC to authorize payment for acceptable data collection forms.

ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
Authorization Form

This form is completed at the Clinical Coordinating Center to authorize payment to a clinical center for acceptable completion of data forms.

1. Patient Registry ID:..... ___ ___ ___ ___ ___
2. Patient name code:..... ___ ___ ___ ___
   a. Clinical Center code number ..... _
3. Visit date:..... ___ ___ /
   mo
   a. Visit Number: ..... _
4. Forms payment type:
   ___(1) F
   11/01/93)
   eld **after** 11/01/93)

No SAS Dataset Made For This Form

er: _____

d check to: _____

_____ Date

_____ Authorized Signature

Comments: _____

_____

_____

_____

ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
Unable to Authorize Payment Form

This form is completed by CCC personnel when a visit packet cannot be authorized.

1. Patient Registry ID: ..... ___ ___ ___ ___ ___

2. Patient name code: ..... ___ ___ ___ ___

   a. Clinical Center code number ..... ___ ___

3. Visit date: ..... ___ ___/ ___ ___/ ___ ___
   month day year

   a. Visit Number: ..... ___ ___

4. Original forms payment type:

   ___(1) Follow-Up ($100) (Visit held **before** 11/01/93)

   ___(2) Follow-Up ($200) (Visit held **after** 11/01/93)

5. We regret that we are unable to authorize payment for the visit identified above for the following reason(s):

   ___(1) Visit packet missing form(s) (form missing: __05A __05B __03 __04).

   ___(2) PFT tracings/printouts missing.

   ___(3) Pulmonary function testing was not performed according to Registry protocol. Please review the Manual of Operations regarding performance and completion of pulmonary function testing.

   ___(4) This visit was held within eight months of a previous visit.

   Previous visit date: ..... ___ ___/ ___ ___/ ___ ___
   month day year

   ___(5) Other (Specify _____)

Comments: _____

_____

_____

Form Completed By CCC Staff (Name): _____

Date form completed by CCC staff: ..... ___ ___/ ___ ___/ ___ ___
month day year

Signature of CCC Co-Director: _____