**NORTH MISSISSIPPI MEDICAL CENTER**
**Research Protocol Summary**
*Patient's Addressograph*

**Study Name:**

**Study Purpose:**

**Study Type:**

**Name of Medication:**

**Dosage Form(s):** **Strength(s):**

**Dosing Frequency and Route:**

**Expected Therapeutic Effect(s):**

**Possible Adverse Effect(s) (include symptoms of toxicity and their treatment:**

**Storage Requirements:**

**Significant Food/Drug Interactions:**

**Administration/Handling:**

**Additional Information for Staff:**

**Research Consent Form Signed and on the Patient's Chart (in consent section):**
☐ **Yes** ☐ **No**

**Principal Investigator:** **Phone/Pager:**

**Co-Investigators (list 2-3):**

*** Please contact the Research Coordinator with any concerns or questions:**

**Research Coordinator:** **Pager:** **Date:**

**Charge/Staff RN:** **Date:**

**Inservice given by:**

**Signed: _____ Date: _____**

**Staff Signatures:**

**Charge RN: _____ Date: _____**

**Primary Staff RN: _____ Date: _____**

**Other Staff: _____ Date: _____**

**Other Staff: _____ Date: _____**

**Note: The information provided is a quick reference only. Please refer to the patient's informed consent for additional information OR the full protocol, which is on file in the Pharmacy.**