This patient is a participant in a clinical trial. This form contains information about the investigational drug and comparator agents being utilized in the study protocol.

Please read the information carefully.

**Protocol Title:**

Open Label ____  Blinded ____

**Principal Investigator:**

Sub-Investigator(s):

Research Coordinator(s):

**DRUG DATA**

**Section A** – provide information on the Investigational Drug

**Section B** – provide information on the Comparator Agents (if applicable)

**A. Investigational Drug Name:**

- Pharmacological Class:
- Pharmacological Action:
- Antidotes, if any:

Brief Description of Therapeutic or Diagnostic Indications:

- Dosage Form(s) and Strength(s) used in study:
- Route:
- Administration Schedule (i.e. daily, q12h, q24h):

Potential Adverse Reactions:

Contraindications:

Drug-Drug-interactions:

Drug-Food interactions:
Storage Conditions on floor: _______________________________________________
May This Drug Be Administered By Nursing? ________________________________
  • IV Fluid (Diluent) and Volume: ______________________________________
  • Concentration: ____________________________________________________
  • Rate of Administration: _____________________________________________
  • Infuse through Dedicated Line? ______________________________________

B. Comparator Agent(s) or Placebo** (if applicable): ______________________
  • Pharmacological Class: _____________________________________________
  • Pharmacological Action: ____________________________________________
  • Antidotes, if any: __________________________________________________

Brief Description of Therapeutic or Diagnostic Indications:
________________________________________________________________________
________________________________________________________________________

• Dosage Form(s) and Strength(s) used in study: __________________________
• Route: _____________________________________________________________
• Administration Schedule (i.e. daily, q12h, q24h): _________________________

Potential Adverse Reactions:
________________________________________________________________________
________________________________________________________________________

Contraindications: _____________________________________________________

Drug-Drug-interactions: _________________________________________________
Drug-Food interactions: ________________________________________________

Storage Conditions on floor: ______________________________________________
May This Drug Be Administered By Nursing? ________________________________
  • IV Fluid (Diluent) and Volume: ______________________________________
  • Concentration: ____________________________________________________
  • Rate of Administration: _____________________________________________
  • Infuse through Dedicated Line? ______________________________________

PHYSICIAN / NURSING IMPLICATIONS

• Special Monitoring of Patient (i.e. vital signs, laboratory studies, etc.):
  _____________________________________________________________________

• Length of Treatment: _________________________________________________
• Prohibited Concomitant Medications: _________________________________
Supplies Available in Inpatient Pharmacy? ________________________________
Location of Supply, if not Pharmacy: ________________________________

Unused Investigational Drug must be returned to the Department of Pharmacy.

CONTACT INFORMATION

Principal Investigator        Phone: __________
Study Coordinator            Phone: __________

IRB #

Completed IDDS Forms are to be submitted to the Research Pharmacist in the Inpatient Pharmacy.