Research Inquiry | Walsh Lab

To most quickly inquire about our research, you may print out this form and complete it fully. Please submit this form via a method noted below. You may call 617-919-4795 to check the status if you do not receive a call within a week to ensure it was received. To speed up the screening process you may also wish to complete and submit the provided clinical history summary and family history forms with this inquiry.

Mail: Walsh Lab Study Inquiry | 300 Longwood Avenue, BCH 3150 | Boston, MA 02115
Fax: 617-919-2300
Email: walshresearch@childrens.harvard.edu

Patient Information

Patient's Name:________________________________ **Date form submitted:**________________

Gender (check): Male Female Current Age: ________ **Date of Birth**:________________

Referred by: ____
Health Care Provider Name Hospital Affiliation Office Phone Number

Name and Contact Information for Person Completing Form/Making Inquiry

Name:____

Relationship to Patient:____________________________________

Phone (Please check preferred number):

Home:________________ **Cell:**________________ **Work:**________________

Mailing Address: ____

____

Email Address: ____

Patient Symptoms (please complete the separate clinical history summary to provide more details)

Brain MRI structural abnormality NO YES Type:____________________ **Age diagnosed**______

Seizures NO YES Type: ____________________ **Age diagnosed**______

Other:____

____

For Walsh Lab use only:

Inquiry Form Rc'd via: Fax Email Post Date Inquiry Rc'd: ____________________

Screening Forms Rc'd: ________________ Inquiry Logged by/date: ____________________

Submitter Notified date:________________ Coordinating GC: ____________________