Enrollment Form - Version 1.0

This form should be completed after the patient gives consent to participate in the GO Project.
Fold in half and seal this preaddressed, postpaid form and mail to the Data Coordinating Center.
Please print or type. Thank you!

Physician Information

Surgeon of record for this patient's enrollment surgery

Neurosurgeon _____ _____
First Name Last Name

Hospital / Clinic _____

Address _____

City _____ State _____ Zip / Postal Code _____ - _____

Telephone Number (__ __ __) __ __ __ - __ __ __ __

Fax Number (__ __ __) __ __ __ - __ __ __ __

Study Coordinator _____

Telephone Number (__ __ __) __ __ __ - __ __ __ __

Fax Number (__ __ __) __ __ __ - __ __ __ __

Patient Information

Patient Name _____ ___ _____
First Name MI Last Name

Social Security Number __ __ __ - __ __ - __ __ __ __ (or Social Insurance Number in Canada)

Date of Surgery __ __ / __ __ / __ __
month / day / year

Address_____

City_____ State_____ Zip / Postal Code _____-_____

Telephone Number (__ __ __) __ __ __ - __ __ __ __

Alternate Phone Number (__ __ __) __ __ __ - __ __ __ __