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| **Purpose of this request form** |
| **The purpose of this request form is to provide the required information to assess** **laboratory support required for the project.**  **Instructions and information for requesting Laboratory support for Clinical Trials or Research** **Submit documents to the Lab Research Coordinator:*** **This form RM0100F1**
* **A current e-copy of the Research Study Protocol**
* **A current e-copy of the REB Approval Certificate**
* **An e-copy of the Departmental Agreement for Providing Research Related Services (DAR) Form (as required)**
* **An e-copy of the laboratory Manual, if available**

**Upon receipt of all documents, approval/disapproval for support will be communicated to requestor**  **within 2-3 weeks.*****Note: By submitting this form, the researcher agrees to pay the review fee and all other costs assessed*.** |

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| **Contact Information** |
| **Qualified Investigator Name** | Click here to enter text. |
| ***Email Address:***  | Click here to enter text. | ***Phone #*** | Click here to enter text. |
| **Clinical Research Coordinator Name** | Click here to enter text. |
| ***Email Address:***  | Click here to enter text. | ***Phone #*** | Click here to enter text. |
| **Nurse Coordinator Name (if applicable)** | Click here to enter text. |
| ***Email Address:***  | Click here to enter text. | ***Phone #*** | Click here to enter text. |
| **Data Coordinator Name** **(if applicable)** | Click here to enter text. |
| ***Email Address:***  | Click here to enter text. | ***Phone #*** | Click here to enter text. |
| **Study Sponsor Name** | Click here to enter text. |
| **Name of Paying Agency** | Click here to enter text. |
| **Contact Name for Billing Purposes** | Click here to enter text. |
| ***Email Address:***  | Click here to enter text. | ***Phone #*** | Click here to enter text. |
| ***Complete Mailing Address******(Use separate lines for Street Address, City, Province, Postal Code)*** | Click here to enter text |
| **Project Information** |
| **Date of Request** | Click here to enter a date. | **Study Acronym** | Click here to enter text. |
| **Name of Study**  | Click here to enter text. | **Protocol Number** **and Version** | Click here to enter text. |
| **Is this a Health Canada/****FDA regulated study?** | **Y** [ ]  **N** [ ]  | **FHREB# or UBC BCCA REB#** | Click here to enter text. |
|  **Is this study currently under review or in place at any Lower Mainland Lab site(s)? Please list all that apply** **or enter "Does Not Apply"**Click here to enter text. |
| **Start Date:** | Click here to enter a date. | **Estimated Completion Date:** | **Click here to enter text.** |
| **Expected Number of Patients** | Click here to enter text. |
| **Select Patient Type:** | **Choose an item.** |
| **Local site support requested from:** **ARH** [ ]  **BH** [ ]  **RCH** [ ]  **SMH** [ ] [ ]  **Other:** Please specify |
| **Required Laboratory Involvement** |
|  |
| **Specimen collections** |
| **Blood** [ ]  **Urine** [ ]  **Stool** [ ]  **Sputum** [ ]  **Bone Marrow** [ ]  **Other** [ ]  **If other, please specify:** Please Specify |
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|  **Laboratory Testing**  |
| ***Note: Laboratory support is available weekdays from 0800 -1400 only.******If support is required outside of these hours, list requirements here and discuss with LRC***Click here to enter text. |
| **Is standard of care testing required?** |  Yes [ ]  |  No [ ]  |
| **If yes, list each individual test** | Click here to enter text. |
| **Is non-standard of care testing required?** |  Yes [ ]  |  No [ ]  |
| **If yes, list each individual test** | Click here to enter text. |
| **Acknowledgement & Submission** |
|  Initial review fee is non-refundable and invoiced upon submission of this form. The fee is dependentUp upon the complexity of the review process and ranges from $200 - $400. F**Note**: BC Cancer – Surrey is excluded from this acknowledgement***I understand that an invoice will be generated for the Initial Review fee.*** [ ]  |

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| **LRC Contact Information** |
| Caroline ArnoldLaboratory Research CoordinatorLower Mainland Pathology & Laboratory MedicineSMH Critical Care Tower, 4th floor 13750 – 96th Ave, Surrey, B.C.  V3V 1Z2  | caroline.arnold@fraserhealth.ca604-585-5666 Ext:774675 |