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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 dependent  Up 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 Arnold  Laboratory Research Coordinator  Lower Mainland Pathology & Laboratory Medicine  SMH Critical Care Tower, 4th floor  13750 – 96th Ave, Surrey, B.C.  V3V 1Z2 | [caroline.arnold@fraserhealth.ca](mailto:caroline.arnold@fraserhealth.ca)  604-585-5666 Ext:774675 |