CCI Laboratory Services Formal Quote Form

Complete Sections I, II and III. Section IV (optional) Forward ALL attachments at the time of submission.

SECTION I – CLINICAL TRIAL/RESEARCH INFORMATION

Date of Request:	**Sponsor:**	**Tumor Group:**
Abbreviated Study Name (for requisition):		
Attached Documents: ☐ **Study Protocol** ☐ **Ethics Approval** ☐ **Laboratory Manual**		
REB / REB#: HREBA		
Protocol Name and Number: vvv		
Funding Type: *(Options: Industry-Initiated / Industry Sponsored / Cooperative Group / Investigator-Initiated Grant)*		
Submit Invoice To: (Name)	**Department:**	**Room #:**
Investigator: (Name)	**Phone Number:**	**Department:**
Study Coordinator: (Name) **Email Address:**	**Phone Number:**	**Fax Number:**
Date Study Begins:	**Date Study Ends:**	
Projected № of Patients locally: ☐ In-Patient - _____ ☐ Out-Patient - _____		**№ of Laboratory Visits/Patient:** _____

SECTION II – LOCAL LABORATORY INFORMATION

Specimens to be collected by: ☐ Laboratory Services ☐ Study Coordinator ☐ Other, Describe _____

Will patient's identity be blinded from Local Lab Results? ☐ Yes ☐ No

Local Lab Testing: (tests to be performed within Edmonton Zone – include hematology, coagulation, chemistry, ECG, toxicology, transfusion medicine, immunohistochemistry etc.)

Services/Tests to be performed by Alberta Health Services - Laboratory Services that are <u>over and above</u> Standard of Care? ☐ No ☐ Yes, please specify which testing below.

Note: Please list the services or tests (<u>over and above</u> standard of care). Record the test code or name of all tests (not panels (i.e. CBC, Glucose, NA, K)

_____

Tests listed above required on a STAT basis? ☐ No ☐ Yes, please specify: _____	**Tests listed above submitted outside of 0700-1700 hours?** ☐ No ☐ Yes, please indicate why: _____

Will the study require the services of one of the following Laboratory Services departments:

Anatomical Pathology Services: Does this study require Anatomical Pathology services such as tissue procurement, tissue biobanking, tissue processing and slide and/or block pulls? ☐ No ☐ Yes

If yes, please specify what service is requested: _____

Transfusion Medicine ☐ No ☐ Yes, If yes, please specify what service is requested: _____

Provincial Laboratory: Request for operational approval must be submitted directly to Provincial Laboratory.

SECTION III – CENTRAL LABORATORY INFORMATION

Will a Central Laboratory be used for testing? ☐ No ☐ Yes (Complete this Section)

Name of Central Lab(s) to be used if applicable: _____

Central Laboratory Manual Attached ☐ Yes ☐ No Please forward to Laboratory ASAP.
☐ No Central Lab Manual available

Specimens to be packaged and shipped (if applicable) by: ☐ Laboratory Services ☐ Study Coordinator
☐ Other, Describe _____

Shipping Supplies Provided by Sponsor/Central Lab: _____
Courier Service to be used: _____

If the protocol involves genetic or PK/PD substudies, will CCI be participating? ☐ No ☐ Yes
If yes, please specify: _____
Will PK specimens be collected outside of the hours of 0700-1700? ☐ No ☐ Yes Specify: _____

SECTION IV – STUDY COMMENTS

Additional Research Study Information:

_____

SECTION V – FOR LABORATORY USE ONLY