**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**

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| **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**

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| **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 over and above Standard of Care?**   No  Yes, please specify which testing below. | |
| Note: Please list the services or tests (over and above 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**

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| **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**

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| **Additional Research Study Information:** |  |
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**SECTION V – For Laboratory use Only**

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