**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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