**PLACE LOGO HERE**

**INSTRUCTIONAL TEXT: (delete this box after reading)**

1. The entire form can be formatted to meet the laboratory’s needs.
2. All **purple, bold font** should be updated for your lab. Once updated, change to regular black font (not bold).
3. The document can be locked as a form by selecting “Restrict Editing” in the Review tab in the ribbon above, and click the box under “Editing restrictions in the side bar to the right” and select “filling in forms” in the drop down box. Click on “Yes, Start Enforcing Protection” to lock the document.
4. You can unlock the document to edit by selecting “Restrict Editing” in the Review tab in the ribbon above, and clicking the “Stop Protection” button at the bottom right.

Clinical Laboratory Request

**Instructions:**

1. Complete appropriate sections as instructed below in *“*[*Type of Support Requested*](#_Type_of_Support)*”*
2. Attach additional information regarding lab collections/processing and/or testing
3. E-mail to: **[ENTER RESPONSIBLE PARTY AND EMAIL ADDRESS]**

NOTE: Requests may be denied if funding or other resources are not available to support the request. Any support requiring the purchase or implementation of additional equipment necessary for specimen processing, storage, or shipping may require additional time and any costs associated with such requirements may be the responsibility of the requesting cost center.

### Submission information:

Submitted by:       Date of Submission:   /  /

Please indicate whether Clinical Laboratory support needs to be available prior to a specific date or event: Date: **/****/**Event:

TO BE COMPLETED BY CLINICAL LABORATORY REPRESENTATIVE:

Received Date/Initials:       /

### Requestor information:

**Organization Requesting Clinical Laboratory Support:**

|  |  |  |
| --- | --- | --- |
| Organization Name | |  |
| Cost Center (Division / Branch) | |  |
| Unit Location (Address) | |  |
| City, state, ZIP Code | |  |
| Phone number | | -   - |
| Contact name / title |  | |
| Phone number | -   - | |
| E-mail address |  | |
| Conducting / Requesting Physician |  | |

### Billing Information (if applicable):

|  |  |
| --- | --- |
| Organization |  |
| Address |  |
| City, state, ZIP Code |  |
| Phone number | -   - |
| Fax number | -   - |
| Cost Center (if applicable) |  |
| Account number |  |
| Mgmt. accounting contact / ext. |  |

### Type of Support Requested:

##### Clinical Trial / Health Fair / Wellness Screening Support

###### \*COMPLETE [SECTION 1](#_Section_1_–) ONLY\*

Check all that apply:

Specimen Collection – Indicate specimen type(s):  Other:

Specimen Processing – Centrifugation, Aliquotting, Specimen Storage

Specimen Analysis – Trial participants will be

NOTE: The Laboratory DOES NOT provide packing and shipping services for Clinical Trial specimens.

##### Point of Care Testing

###### \* COMPLETE [SECTION 2](#_Section_2_–) ONLY\*

Check all that apply:

New Equipment / Test – (Enter specific request here)

Additional Equipment – (Enter specific request here)

Additional user training – (Enter specific request here)

##### Laboratory Collection, Analysis, and Sample Request

###### \*COMPLETE APPROPRIATE FIELDS UNDER SECTION 3\*

Check all that apply:

1. [Sample / result requests](#_SAMPLE_/_RESULT)

2. [Testing / result requests](#_TESTING_/_RESULT)

3. [Collection / processing requests](#_COLLECTION_/_PROCESSING)

##### Other Requests

###### \*COMPLETE SECTION 4 ONLY\*

[Laboratory Report Modification](#_Laboratory_report_modification) - (Enter report name here)

[Other Laboratory Support](#_Other_Laboratory_Support)

## Section 1 – Clinical Trial / Health Fair / Wellness Screening Support request:

**Clinical Trial Sponsor (if applicable):**

NAME OF TRIAL / EVENT:

|  |  |  |
| --- | --- | --- |
| Organization Name | |  |
| Division / Branch | |  |
| Cost Center (if app.) | |  |
| Address | |  |
| City, state, ZIP Code | |  |
| Phone number | | -   - |
| Contact name |  | |
| Phone number | -   - | |

**Technical support - (Attach a copy of detailed instructions to this application.)**

Provide a detailed explanation of the support being requested from the Clinical Laboratory – include special instructions, requested supplies, estimated time requested for collections, processing, testing, shipping, etc.

**Coordination with other groups or departments -**

If applicable, list any additional companies/departments that are expected to participate in the clinical trial and the services they will provide.

**EDIT INFORMATION IN BOX BELOW FOR CHARGING AS APPROPRIATE FOR YOUR ORGANIZATION:**

TO BE COMPLETED BY CLINICAL LABORATORY REPRESENTATIVE:

Study Code for charges (if applicable):

STDY20  STDY30  STDY40 Other: (Enter amount >40)

## Section 2 – POCT Support request:

**Technical support** - (Attach a copy of detailed instructions to this application.)

1. What is the goal of this implementation?

2. Can a current procedure be modified to attain the same desired effect?

3. Is there a specific instrument / method in mind?

4. Department purchasing the analyzer(s):

5. Number of analyzer(s) requested:

6. Supplies / consumables needed for testing:

7. Number of staff to be trained:

TO BE COMPLETED BY **LABORATORY SPECIALIST - POCT**:

1. List price of analyzer / method:
2. Cost of supplies / consumables (list all):
3. Expected test volume (tests/yr):
4. Expected location(s) of instrument(s) and supplies:
5. Is monitored refrigeration required?
6. Who will be responsible for monitoring?
7. Number of docking (downloading) stations needed (if applicable):
8. Specifically, where are the docking stations to be located?
9. Are power outlets and data ports available in the designated locations for the docking stations?
10. Expected frequency of New Hire training:
11. Will testing personnel be able to meet this requirement?
12. Is this a new test that will have to be created by the LIS (Laboratory Information Systems) or IT department?
13. List all information systems involved:

## Section 3 – Laboratory Collection, Analysis, and Sample Request:

#### SAMPLE / RESULT requests –

Requests for samples with or without results to be used for validation, comparison testing, or other purposes:

**Reason for request:**

**Mark all that apply:**

|  |  |  |  |
| --- | --- | --- | --- |
| Specimen Type(s): | Cost/tube | Quantity | Total |
| Whole Blood Specimen(s): | **[Enter your lab price]** |  |  |
| Serum / Plasma Specimen(s): | **[Enter your lab price]** |  |  |
| Urine (unspun) Specimen(s): | **[Enter your lab price]** |  |  |
| Urine (spun) Specimen(s): | **[Enter your lab price]** |  |  |
| Body Fluid Specimen(s): | **[Enter your lab price]** |  |  |
|  |  |  |  |
| Additional Charge(s): | Cost/tube | Quantity | Total |
| Include Test Result(s): | **[Enter your lab price]** |  |  |
| Manual Testing Process: | **[Enter your lab price]** |  |  |
| Specialized / High Cost Test(s): | **[Enter your lab price]** |  |  |
|  |  |  |  |
| Total Charges: |  |  |  |

**Notes:**

“Specimen Type(s)”:

* Charges should only be applied when the specimen is collected or processed (aliquotted, centrifuged, etc.) by Clinical Laboratory staff.

“Additional Charge(s)”:

* Should only be applied when test results are being requested for comparison, validation or other laboratory operation processes.
* Should not be applied if the client will also be billed for the test to be performed at the Clinical Laboratory.

#### TESTING / RESULT requests –

Requests to submit samples for testing and results to be used for validation, comparison testing, or other purposes:

**Reason for request:** Enter details for "Other"

**Mark all that apply:**

|  |  |  |  |
| --- | --- | --- | --- |
| Tests Requested: | Charge/test (to be entered by Lab) | Number of samples | Total Charges |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Total Charges: |  |  |  |

#### COLLECTION / PROCESSING support -

Provide a detailed explanation of the support being requested from the Clinical Laboratory – include special instructions, requested supplies, collection time, processing time, shipment support, testing equipment / methods, etc.

## Section 4 – Other Laboratory requests:

#### Laboratory report modification -

Provide a detailed explanation of the modification being requested – include rationale behind the request and anticipated impact to the Health System.

#### Other Laboratory Support -

Provide a detailed explanation of the support being requested – include rationale behind the request and anticipated impact to the Health System.

TO BE COMPLETED BY **CLINICAL LABORATORY REPRESENTATIVE**:

Final Determination:

## Status:

Entered by:

Date: