CLINICAL LAB SUPPORT
SPECIAL STUDY REQUEST FORM

TO: Laboratory Administration

FROM:

DATE:

PLEASE ANSWER QUESTIONNAIRE BELOW AND CALL 617-636-7216 (LAB ADMINISTRATION) FOR ANY QUESTIONS REGARDING THE SPECIAL STUDY REQUEST FORM

If the Study is being changed in any way from a previous submission (whether new grant number/different tests) **please fill out a new form and make sure the existing client number that was assigned is noted below** (revised).

IMPORTANT NOTICE:

STUDY REQUESTS HAVE TO BE SUBMITTED **AT LEAST 2 WEEKS PRIOR** TO TESTING. INCOMPLETE REQUESTS WILL NOT BE PROCESSED.

WHEN STUDY ENDS, PLEASE NOTIFY TINO HERNANDEZ AT 617-636-7216 OR BY EMAIL AT **CHERNANDEZ1@TUFTSMEDICALCENTER.ORG**

♦New Special Study: ☐ Yes ☐ No

♦Revised Special Study: ☐ Yes ☐ No

If YES, current study ID number: _____

I) Study Name: _____

II) P.I.: _____

E-mail: _____

Phone #: _____ Fax #: _____ Mail Box _____

III) Study Coordinator *(contact for study questions)*: _____

E-mail: _____

Phone #: _____ Fax #: _____ Mail Box _____

IV) Person Responsible for Invoices _____

E-mail: _____

Phone #: _____ Fax #: _____ Mail Box _____

V) Results *(automatic reports will be sent to)***:**

Network Printer _____ *or* Fax # _____ *or* Mail Box _____

(RESULTS WILL BE SENT DIRECTLY TO THE PRINTER OR FAX. RESULTS WILL NOT SHOW UP IN SOARIAN)

VI) Outside Client *(only for Clients **not** associated with Tufts)*:

_____

(Address to where invoices should be sent- full address and contact needed)

VII) # of subjects expected: _____ Testing Schedule: _____

Expected start date: _____ Expected End Date: _____

PLEASE READ CAREFULLY:

BILLING/ACCOUNT NUMBER (200 hospital, 250 research):

PLEASE USE LAWSON NUMBERS (For 250 Acct #- need all 28 digits. For 200 Acct #- need all 12 digits)

- The Account # provided **WILL AUTOMATICALLY BE CHARGED** for the testing activity of the month. An internal transfer of funds will be done by the Pathology billing coordinator, in collaboration with Research Finance and General Accounting.

THE INVOICE SENT TO YOUR ATTENTION IS FOR YOUR RECORDS ONLY

GRANT NUMBER: __ __ __/__ __ __ __ __ __/__ __ __ __ /__ __ __ __ __ __ __ __ __ __ __ __ / __ __ __ __ __ (PROVIDE ALL 28-DIGITS)

[Comp #] / [Acct Unit] / [Acct #] / [Activity #] / [Acct Category #]

♦**CTRC STUDY?** *(please check box)*: ☐ ♦**SIGNATURE OF CTRC MANAGER:** _____

♦**EXPECTED DURATION OF STUDY**: _____

- Studies not supported by an Account #/grant, **REQUIRE PAYMENT BY CHECK** (within **30** days of invoice) issued from department. Study requests will not be processed if the required information is not available.

Any questions or concerns should be addressed to Tino Hernandez at (617) 636-7216

VIII) BE SPECIFIC WITH EXACT TESTS/PROCESSES NEEDED *(Do not group together. Include frequency of testing and total volume of testing)*:

- How are the samples being drawn & sent to the Lab? : _____
- Is patient being drawn from a Designated Phlebotomy Area? : ☐ Yes ☐ No (please check one)
- Will one of our Phlebotomist be needed to draw samples? : ☐ Yes ☐ No (please check one)
- Will sample already be drawn and sent to the lab? : ☐ Yes ☐ No (please check one)

Any Comments:

INSTRUCTIONS

1. Download or Print this form. (Portrait)
2. Fill out request with complete information. Study will not be processed unless **ALL** information is provided.
3. Expect study to begin as soon as all paper work and information has been completed. Study will be reviewed by all Laboratories that are involved in testing.
4. SPECIMENS WILL NOT BE PROCESSED UNTIL STUDY IS FULLY COORDINATED AND YOU HAVE RECEIVED YOUR REQUISITION.
5. **PRICE QUOTES FOR TESTING ARE SUBJECT TO CHANGE.**