Tufts Medical Center

Department of Pathology and Laboratory Medicine
Special Studies Requisition

Please fill in the fields below to the best of your abilities with as much detail as possible. Please note that study requests must be submitted *at least 2 weeks* in advance. Any questions regarding this special study request form should be directed to:

Nicholas Heger, PhD
Medical Director of Clinical Operations
nheger@tuftsmedicalcenter.org

Study Information

Study name: ______________________________

Expected Start Date: ______________ Expected End Date: ______________

Total number of specimens expected: ______________________________

Testing frequency:

____

Contact Information

Principal Investigator: ______________________ Phone: ______________

E-mail: ______________________ Fax: ______________

Study Coordinator: ______________________ Phone: ______________

E-mail: ______________________ Fax: ______________

Invoice Coordinator: ______________________ Phone: ______________

E-mail: ______________________ Fax: ______________

Billing Information

Please indicate the source of your funding:

- **Federal grant**
- **Pharmaceutical/Biotech**
- **Other (please explain below):**

List your Tufts MC cost center/grant number or full billing address. Studies affiliated with Tufts University, including the Dental and Medical School, will need to list a full address.

Phlebotomy Services and Specimen Collection

1. Will phlebotomy services be needed for this study?

   YES: **NO:**

   Inpatient study subjects: If no, skip to next section (Testing Services)

   Outpatient study subjects:

2. Where is the blood drawing occurring?

   Biewend 3 Outpatient Clinic: South 5: Floating 3 (Pediatrics Only):

   Inpatient (please list and explain patient locations below):

3. Will the study coordinator accompany the patient to the blood draw? **YES:** **NO:**
4. Is the study supplying the blood collection tubes? **YES:** **NO:**

   If **YES**, please describe the tubes and provide manufacturer information:

Testing Services and Specimen Processing

1. Will clinical laboratory testing services be needed for this study? **YES:** **NO:**
2. Which tests from the clinical laboratory are being requested?

   (You can find a list of all our tests on our Directory of Services)

3. How should results be sent to you?

   Printer network name OR Fax number: ______________________________

4. If testing is NOT being performed at the Tufts Medical Center clinical laboratory, please select the processes below that are being requested of the clinical laboratory:

   Centrifugation: **Aliquoting:** **Send outs:** **Other (fill in below):**

Miscellaneous/Other Requests