UF Clinical and Translational Science Institute
Clinical Research Center
UNIVERSITY *of* FLORIDA

OFFICE USE ONLY
CRC Project #_____
Date Rec'd _____

Clinical Research Center Request for Services Form

Protocol Title:			
Study Short Title:			
Sponsor / Funding Source:			
Sponsor Protocol Number:			
IRB # (if available):		IRB Expiration Date:	
OCR# (if available)			
Principle Investigator:			
PI Department:			
PI Email Address:			
PI Phone Number:			
Co-Investigators:			
Project MD:			
Primary Study Coordinator:			
Study Coordinator Email:			
Study Coordinator Phone:			

Please indicate service/support needed from CRC and click the 'submit' button at the bottom. Additional documents are required and will be attached at the bottom of this form.

Please make sure you are using the most recent version of this form. If you are not sure you may download the latest version HERE

PLEASE MAKE SURE REQUESTED DOCUMENTS ARE ATTACHED OR YOUR REQUEST MAY BE DELAYED

UF CLINICAL RESEARCH CENTER SERVICES NEEDED

1. What is the participant population? (check all that apply)
   - ☐ Children ☐ Adults ☐ Elderly
2. What is the Age Range of Participants? _____ years of age
3. How many participants do you plan to enroll? _____
4. What is the projected start date of the study? _____
5. What is the anticipated duration of the study? _____ Months
6. What type of visits will be needed? (check all that apply)
   - ☐ Outpatient visits during regular CRC hours (7:00 am – 5:00pm)
   - ☐ Extended hours (5:00pm – 12:00am)
   - ☐ Overnight visits (5:00pm – 7:00am)

Indicate nursing services needed for extended and overnight visits:

_____

☐ Scatter-bed services (CRC will provide research nursing coverage for participants in Shands Hospital or other facility on campus between 7:00am – 5:00pm)

Please indicate the services the scatter-bed CRC nurse will provide:

_____

7. Do you need a room with: (check all that apply)

☐ Hospital Bed ☐ Chair ☐ Stretcher

8. NURSING SERVICES – Please indicate the nursing services requested: (check all that apply)

☐ Vital Signs Select Type
☐ Height/Weight
☐ Blood Draw Select Type
☐ Specimen Collection Select Type
☐ IV Catheter Placement
☐ BMR
☐ BodPod
☐ Finger Stick
☐ EKG Select Type
☐ Pre-IP Medications
☐ Administration of Study Medication (IP) Select Route
☐ Administration of IV Fluids
☐ Conscious Sedation for procedure (specify procedure): _____
☐ Assistance with procedure(s) (please specify): _____
☐ Other (specify) _____

9. INVESTIGATIONAL DRUG SERVICES – (Check all that apply)
(Please contact IDS@shands.ufl.edu if you check any of the boxes below for a separate cost estimate)

☐ Research Protocol involves Investigational Drug
☐ Emergency medications needed
☐ Routine medications needed (includes pre-meds and medications to treat anticipated reactions)
☐ Performing Conscious Sedation
☐ Local anesthetics for a procedure

10. UF CRC LAB SERVICES (check all that apply)

☐ Lab manual for this study is available and will be provided
☐ Simple sample lab processing (spin, separate and transfer to aliquot)
☐ Complex sample lab processing (includes use of additives, incubation or any other complex processing)
☐ Urine HCG/pregnancy testing
☐ Send sample for Shands Lab analysis
☐ Dry ice for shipping from CRC (FedEx picks up daily between 1530 – 1630).
Dry ice can be pre-ordered 1 week in advance of use. Please indicate amount in lbs and date needed and email tomathew@ufl.edu
☐ Temporary Storage at CRC (2 weeks)
☐ Plan on using CTSI biorepository (beyond 2 weeks sample storage)

Please list all lab tests required (blood, urine, stool, spinal fluid, saliva, others), if lab kits are provided by sponsor and where analysis/final storage will take place.

Lab Tests	Kits Provided?	Analysis done at?	Same day shipping?
Example CBC	*No*	*Shands*	*N/A*
Example Drug Level	*Yes*	*Central Lab*	*Yes*
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select
	Select		Select

11. EQUIPMENT USE

☐ Study will require the use of CRC equipment

- Specify equipment needed: _____

☐ Study Team will bring equipment to CRC

- Specify equipment and space needed: _____
  (Storage of equipment within the CRC is not guaranteed, please contact Nurse Manager for approval)

12. REQUIRED DOCUMENTS: Please click the buttons below to attach required document files:
PLEASE MAKE SURE REQUESTED DOCUMENTS ARE ATTACHED OR YOUR REQUEST MAY BE DELAYED

Attach Protocol
Attach Draft ICF
Attach PI CV
CLEAR FILES

13. OPTIONAL DOCUMENTS: Please click the button below to attach document files such as lab manual. Etc.

Add documents
CLEAR FILES

When you have completely filled out the form and attached the required documents please Click the Submit Button

SUBMIT