UBC Hospital CTRU Service Request

Complete this form for an initial review of study requirements and CTRU feasibility.
Provide known information; enter "pending" for details not yet available.
Submission does not authorize study activities. Do not include participant identifiers.
Save a copy after completion. Attach more detail if an answer does not fit.

1 Study information and contacts

Study title

Protocol number / study acronym

Protocol version and date

Principal investigator

Sponsor

VCHRI study number (if assigned)

FAS number (if assigned)

REB of record / study number

REB status

Select...

Primary study contact

Name

Role

Email

Phone

Institution / department administering funds

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Services and visit planning

2 CTRU services requested

Select all that apply. Requests are subject to CTRU feasibility review.

- ☐ Participant assessment and monitoring
- ☐ IV therapy / infusion
- ☐ Specimen collection
- ☐ 12-lead ECG
- ☐ Vital signs
- ☐ Investigational product administration
- ☐ Pharmacokinetic / timed blood sampling
- ☐ Specimen processing
- ☐ Continuous cardiac monitoring
- ☐ Procedure support
- ☐ Other

Administration route(s), if applicable

Briefly describe the services requested from CTRU

Procedure / medical support needed and who will provide it, if known

3 Participant visits

Estimated number of participants

Estimated CTRU visits per participant

Approximate duration of each visit

Estimated frequency of visits

Are visits anticipated outside regular CTRU operating hours?

- ○ Yes
- ○ No
- ○ To be determined

If yes, please describe the timing or overnight stay required

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Department requirements

4 Pharmacy laboratory and radiology

Departmental approvals may be pending at initial feasibility review.

Pharmacy

Does this study require pharmacy services?

○ Yes ○ No ○ To be determined

Pharmacy review / approval status

Select...

Laboratory

Does this study require laboratory services?

○ Yes ○ No ○ To be determined

Laboratory review / approval status

Select...

Briefly identify the laboratory tests required

Radiology

Does this study require radiology services?

○ Yes ○ No ○ To be determined

Radiology review / approval status

Select...

Briefly identify the imaging required:

Note: Existing Pharmacy, Laboratory, and radiology approval processes should continue to be followed. Where possible, please prioritize approvals, as these are required to initiate CTRU operational and Cerner build processes.

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Cerner planning

5 Cerner planning

Provide known information; enter "pending" for details not yet available.

Previous Cerner build or similar trial

Are you aware of an existing Cerner build or a similar trial that may be useful as a reference?

○ Yes ○ No ○ Not sure

Study title / protocol, site, and build / order set details (if known)

Reference contact and relevant similarities / differences (if known)

Study team Cerner access and training

List study team members who will use Cerner. Attach another page if needed.

Enter "pending" if a username is not yet assigned. Do not include passwords.

Name / role	Cerner username	Access status	Training status
		Select...	Select...
		Select...	Select...
		Select...	Select...
		Select...	Select...

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Documents and submission

6 Study documents

Select the documents provided with this request. Pending documents may follow.

- [ ] Current protocol
- [ ] Schedule of assessments
- [ ] Investigator's brochure
- [ ] Pharmacy manual
- [ ] Pharmacy approval
- [ ] Laboratory manual
- [ ] Laboratory approval
- [ ] Radiology manual
- [ ] Radiology approval
- [ ] REB approval letter
- [ ] Other

7 Additional Requirements

Include equipment, supplies, staffing, space, accessibility, training or timing needs.

8 Additional Information

Is there anything else that would be helpful for the CTRU team to know when reviewing this request?

Submit your request

Date completed (DD/MM/YYYY)

Completed by

Email the completed form and available documents to:

CTRU@vch.ca

Format the email subject as: Study name - Date