UCLA Department of Pathology & Laboratory Medicine
David Geffen School of Medicine at UCLA

Center for Pathology Research Services

Please submit this application to CPRS@mednet.ucla.edu **at least 2-3 weeks prior** to the beginning of the research for approval. All UCLA studies using patient medical record numbers/identifiers must be registered in CareConnect. Studies not registered in CareConnect, will not be issued a requisition until registration has been completed. Studies NOT using patient medical record numbers/identifiers do not need to register in CareConnect.

Please note that samples will not be accepted/processed until this application has been approved and a research requisition is created.

STUDY INFORMATION		
Principal Investigator:	Phone:	Email:
Primary Coordinator:	Phone:	Email:
Dept & Affiliation:		Dept. Code:
Mailing Address:		Mail Code:
Grant & Fund Account (**FAU**):		**Recharge ID**:
Billing Contact:	Phone:	Email:
Research Funding: ☐ NIH Funded	☐ Industry Funded	☐ Department Funded
Short Study Protocol Title:		
Start Date:	**End Date**:	

IRB		**IBC**	
IRB Number:	IRB EXP:	IBC Number:	IBC EXP:

Where will subjects be seen? Check all that apply.

☐ **UCLA RR** ☐ **UCLA SMH**

☐ **UCLA MP200** ☐ **CTRC***

☐ **Other** _____

***If using other locations, list all locations and coordinators in the additional comments section.**

*CTRC Protocol Number:

Notify us prior to sending infectious samples

Will samples contain any known infectious agents?
☐ **Yes** ☐ **No**

***If yes, please list IBC containment level, post-exposure plan, type of materials and sources in the additional comments section.**

Is this virus replication incompetent?
☐ **Yes** ☐ **No**

Is the insertional gene oncogenic?
☐ **Yes** ☐ **No**

Will there be toxin or immunomodulary or harmful peptide produced due to infection?
☐ **Yes** ☐ **No**

Are there cell culture lines infected by virus?
☐ **Yes** ☐ **No**

Subject/Sample Identification

Please select ONE identifier.

☐ **MRN with *CareConnect***

Results will be viewable in *CareConnect*.
If using **PAPER** requisition, then requires NAME, MRN, DOB, GENDER

Patient encounter must be linked to the study in CareConnect!

☐ **Anonymous ID with Fax/Network Printer***

DO NOT INCLUDE PHI!!

Requires Study ID, Year of Birth, and Gender for proper reference range.
ID Example: IRB99-999999 PT,(insert study ID)

FAX Number is REQUIRED for results

COMPLETE FAX:

☐ **PATIENT DECLINED Anonymous ID**
No year of birth and gender provided.

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SPECIMEN INFORMATION

Estimated Amount of Participants: _____

Samples Submitted at a time:
☐ 1 ☐ 2-5 ☐ ≥5

BIOFLUID PROCESSING AND HANDLING

☐ Local Lab Tests ☐ Research Lab Kit Processing ☐ PBMC Processing

Will the study send samples ***outside business hours***?
Sample Receiving Time M-F 8:00a-5:30p (PBMC 4:30), Weekends 9:30a-4:00p (PBMC 3:30)
☐ YES ☐ NO
***Please notify PRP in advance if sending samples afterhours or weekends.**

Will the study provide PRP with ***supplies***?
☐ Research Lab Kits ☐ Cryovials ☐ Labels ☐ Reagents ☐ Study requires PRP supplies

TISSUE PROCUREMENT AND HANDLING

Type of Tissue & Anatomic Location to be procured (specify):

Procedure type:
☐ Biopsies (IR) ☐ Biopsies (NON-IR) ☐ Surgery (OR) ☐ Autopsy ☐ Other (please specify):_____
***PLEASE ATTACH TISSUE PROCESSING INSTRUCTIONS AND (PRIOR TO PROCEDURE) PROVIDE SUPPLIES**

FRESH RESEARCH BIOPSY
***MUST APPLY TO INTERVENTIONAL RADIOLOGY**

☐ Collect Cores for ***Research*** **Outside SOC** ☐ Collect Cores for **Standard of Care (SOC)**

Do you need an official Pathology and Cytology report to be issued in the patient's medical record?
☐ YES ☐ NO ☐ Limited Pathology Work up
***If you answer NO, this is considered a research specimen only for the remainder of this section**

☐ **Additional IRB Collection** (Secondary IRB number): _____

Biopsy tissue needs to be picked up from **RR Grossing 3220** (**SM – drop off kit and pick up Gross Room 3594**). Must leave notes for media storage requirements. Must sign Tissue release form to pick up tissue.

FRESH SURGICAL RESEARCH TISSUE

☐ Normal ☐ Tumor ☐ Remnant Tissue | Min Size Required: _____

Study team will be notified when tissue is ready for release.

Tissue Services

☐ **STUDY REQUIRES ADDITIONAL STUDY SPECIFIC REQUIREMENTS**
Please list additional services (such as special stains, IHC, etc) in the additional comments below.

☐ **ARCHIVED SLIDES** ☐ **TISSUE BANKING** ☐ **OTHER** _____

Party to be invoiced for research services charge
☐ Study Sponsor ☐ Patient Insurance ☐ Mixed Billing ☐ Do not know

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SAMPLE SHIPMENT
Do you want the CPRS to **ship** your specimens? ☐ YES* ☐ NO
***NOTE: IF YES, PLEASE PROVIDE SHIPPING INSTRUCTIONS, AIRBILLS AND LABELS**
SAMPLE STORAGE
Will you need to **store** your specimens at PRP?
☐ YES* ☐ YES (<5 Days)* ☐ NO
After **5** Business days, the freezer box rental **monthly rate** applies *even if samples are not stored for a full month*. An individual sample **accession fee** will apply.

Authorized Staff for Sample Pick Up

Appointments are necessary to schedule a pickup during business hours

*Please list staff in **priority order**. Staff will be paged for **TISSUE** Sample Pickup.*

Name:______ Email Address:______ Telephone Number:______ Pager Number:______	Name:______ Email Address:______ Telephone Number:______ Pager Number:______
Name:______ Email Address:______ Telephone Number:______ Pager Number:______	Name:______ Email Address:______ Telephone Number:______ Pager Number:______
Name:______ Email Address:______ Telephone Number:______ Pager Number:______	Name:______ Email Address:______ Telephone Number:______ Pager Number:______
Name:______ Email Address:______ Telephone Number:______ Pager Number:______	Name:______ Email Address:______ Telephone Number:______ Pager Number:______

Will there be Pathology Faculty that will receive Direct Salary support from this study?

☐ **No** ☐ **Yes, ________% or $_____________**

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IMPORTANT NOTE: Unless justified by the protocol and/or required by patient care, Pathology does not provide STAT services for research projects. If STAT is request, the study team may be asked to provide additional justification.

PLEASE LIST ALL LOCAL LABORATORY TESTS

If your study involves **ANY** Local Lab Tests, you are **required** to provide the detailed test information for your application to be processed. **Please indicate whether it is bill to RESEARCH or PATIENT.**
Test codes and assay information is available on our on-line laboratory manual

Test Code	Test Name	CPT Code	Stat	Bill to Patient

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Additional Comments:

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RESEARCH AGREEMENT

INTRODUCTION

Productive, creative and rewarding research activities between Center for Pathology Research Services (CPRS) and a researcher requires both parties to have a clear understanding of the procedures that will occur, each parties' responsibilities and ways that the agreements can be changed, if needed. This research agreement is intended to define and document a mutual understanding of responsibilities of services provided by the CPRS for the following investigator(s) listed in this study application.

SCOPE

The CPRS shall exercise its best efforts to facilitate the services set forth in (**Study Name)** _____ **(IRB protocol #)**_____**,** listed in this study application form, in accordance with this agreement.

RESPONSIBILITIES

General:

1) When research activities involve more than 1 or 2 people from an investigator's team and more than 1 or 2 people from CPRS, there is great potential for miscommunications and misunderstandings, especially when protocols are being changed. To ensure that all members of the research team (including the PI) and CPRS (including the directors and lab manager) are aware of and approve of proposed changes to existing protocols, any amendments to this agreement shall be signed and approved by both the CPRS and Investigator.
2) In the event where specimens will be shared for both research and clinical purposes, CPRS ensure that sufficient specimen is available for diagnosis before releasing any materials to research, and CPRS reserves right to recall research specimens or leaving research requests unfulfilled if required for diagnostic purpose.
3) Our fee schedule may fluctuate over the course of the study.
4) Approved amendments should be in place within five business days.
5) *The appropriateness of testing and result release will be determined by the Pathology and Clinical Laboratory Director. Contact **PRP (310-825-0825)** for questions / investigation on rejected specimens or result release for specific test(s) if testing was performed.*

The Investigator is responsible for:

1) The direction of the research in accordance with applicable policies and protocols.
2) Requesting in writing and obtaining written approval from the CPRS for any changes or amendments in the approved scope of work (services requested).
3) Ensuring CPRS receives all required study specific supplies prior to initiating the protocol.
4) Providing full payment within 30 days after invoice is issued. For accounts delinquent past 30 days, CPRS reserves the right to collect late fees and cancel existing service requests.
5) Notifying the CPRS when the (**Study Name)**_____ **(IRB protocol #)**_____ has ended (*email acceptable*).

CPRS will not be responsible for failing to perform any unapproved changes or amendments to the written and approved scope of work (services requested). If the research team does not follow the mutually agreed upon protocols, CPRS cannot guarantee that the sample will be handled as desired, although every effort will be made to do so.

PERFORMANCE PERIOD

The period of this agreement will be effective immediately after both parties complete the signature, until CPRS receives notification from Investigator that the study has ended.

☐ By checking this box, I confirm that the information in the application is accurate and agree to the terms listed above.

Investigator Signature: _____ Date: _____