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 your earliest convenience, **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 Title:		
CTRC Protocol:	**Start Date**:	**End Date**:
Protocol Summary: (additional space available on page 5)		

Regulatory and Compliance

Do you have current Institutional Biosafety Committee (IBC) approval or Institutional Review Board (IRB) approval for this project? (Check all that apply)

☐ **IRB Approval** (Please attach a copy of approval letter)
☐ **IBC Approval** (Please attach a copy of approval letter)
☐ **IBC and/or IRB Approval Pending.**
☐ **IRB Exempt**
☐ **IBC Exempt**

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

Where will subjects be seen? Check all that apply.
If it is in a location not listed, please list below.

☐ **UCLA RR** ☐ **UCLA SMH** ☐ **Burbank**
☐ **UCLA MP200 St145** ☐ **West Lake**
☐ **Porter Ranch** ☐ **CTRC** ☐ **Other**

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

Notify us prior to sending infectious samples.

Will samples contain any known infectious agents?
☐ **Yes** ☐ **No**
***If yes, please list 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**

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Subject/Sample Identification	
Please select ONE identifier only.	
☐ **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) Requires FAX number for resulting. ***Printer requires additional setup**
☐ **No Result Report Expected** PLEASE SELECT SAMPLE ID ABOVE	COMPLETE FAX: ☐ **PATIENT DECLINED Anonymous ID** No year of birth and gender provided.

Authorized Staff for Sample Pick Up *Please list staff in priority order. Staff will be paged for Sample Pickup.*		
BIOFLUID	☐ **Research Staff Also Authorized to pick up tissue**	**TISSUE**
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:__________
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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FOR STUDIES INVOLVING BIOFLUID SPECIMENS		
Total # of Subjects: _____	**Samples Submitted at a time:** ☐ 1 ☐ 2-5 ☐ ≥5	☐ **TESTING ONLY** ☐ **STORAGE ONLY**

Types of Sample

☐ Whole blood ☐ Plasma ☐ Serum ☐ Urine ☐ Other (Please specify): _____

Type of Processing

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

☐ OTHER (Complex Processing > 2hrs requires a custom quote, please specify)

_____

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

Will the study provide PRP with ***supplies***?

☐ Study Lab Kits ☐ Cryovials ☐ Labels ☐ Reagents ☐ Study requires PRP supplies

Do you want the CPRS to **ship** your specimens? ☐ YES ☐ NO

***NOTE:** IF YES, PLEASE PROVIDE SHIPPING INSTRUCTIONS, AIRBILLS AND LABELS IN THE ADDITIONAL COMMENTS SECTION OR AS ATTACHMENT

Will you need to **store** your specimens at CPRS for longer than 5 business days?

☐ YES* ☐ NO

*If yes, please select storage temperature

☐ Ambient ☐ Refrigerated (2-6 ◦C) ☐ -80 ◦C ☐ -20 ◦C ☐ Liquid Nitrogen

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.

Storage Type
Freezer Storage (-20◦C /-80◦C) per Box per Month
Liquid Nitrogen Storage per Box per Month
Sample Tracking (Accession) in BTM per Sample

NOTE: PLEASE ATTACH PROCESSING SOP OR LIST DETAILED PROCESSING AND SHIPPING INSTRUCTIONS UNDER ADDITIONAL COMMENTS.

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FOR STUDY INVOLVING SOLID TISSUES

Total # of Subjects: _____

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

☐ **ARCHIVED SLIDES ONLY**

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

Procedure type:

☐ Biopsies (IR) ☐ Biopsies (NON-IR) ☐ Surgery (OR) ☐ Autopsy ☐ Endoscopy

☐ Dermatology ☐ Other (please specify):_____

TISSUE PROCUREMENT AND HANDLING

FRESH RESEARCH BIOPSY

MUST APPLY TO INTERVENTIONAL RADIOLOGY

☐ 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

Total Cores/Subject **Outside SOC**: ____

List amount of cores required for each category below.

Cores in *Formalin*: _____	Cores *Flash Frozen*: _____
Cores in *Media*: _____	Media Type: _____

FRESH SURGICAL RESEARCH TISSUE

Tissue Origin:_____ ☐ Remnant Tissue

☐ Normal ☐ Tumor Min Size Required: _____

☐ **Staff Intends to Pick up Tissue from the OR**

☐ **Tissue Procurement Scheduled on Weekends/Evenings**

☐ Tissue in Formalin ☐ Tissue Flash Frozen

☐ Tissue in Media (Media Type_____)

Party to be invoiced for research services charge

☐Study Sponsor ☐ Patient Insurance ☐ Mixed Billing

☐ Do not know

RESEARCH TISSUE PROCESSING AND HANDLING

FORMALIN

☐ Process _____ Cores into _____ Blocks

☐ Release to Study Team Immediately

☐ OTHER (Please Specify):_____

FROZEN

☐ Temporarily Store at TPCL and release with block

☐ Release to Study Team Immediately

☐ OTHER (Please Specify):_____

MEDIA

☐ Release to Study Team Immediately

☐ Temporarily Store at TPCL and release with block

☐ OTHER (Please Specify):_____

☐ **Additional IRB Procurement Desired**

Secondary IRB number: _____

Additional Pathology services requested:

Please specify Test name in Test Section below

Provide additional information if needed.

☐ **Embedding (FFPE / OCT)**	☐ **Special Staining**
☐ **Archived Case Retrieval**	☐ **IHC**
☐ **Unstained Slide Recuts**	☐ **Molecular Test**
☐ **H&E Staining**	☐ **Cytogenetic Test**
☐ **Bio Banking**	☐ **Path Consultation**
	☐ **Other**_____

NOTE: PLEASE ATTACH PROCESSING SOP OR LIST DETAILED PROCESSING AND SHIPPING INSTRUCTIONS UNDER ADDITIONAL COMMENTS.

☐ **STUDY REQUIRES ADDITIONAL STUDY SPECIFIC REQUIREMENT**

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FOR STUDY REQUESTING LABORATORY TESTS

If your study involves tests, you are required to provide the detailed test information for your application to be processed.
Test codes and assay information is available on our on-line laboratory manual

☐ No Testing Required through Pathology

Test Name	**Test Code**	**CPT Code** (Optional)	**STAT** (Yes or No)

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.

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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: _____