Laboratory Medicine
Clinical Study Service Request Form

STUDY DURATION: 
START DATE: 
END DATE: 

PRINCIPAL INVESTIGATOR: 
ADMINISTRATOR: 
CONTACT PERSON: 
PHONE NUMBER: 

MD TO CALL CRITICAL RESULTS TO: 
(MD IS REQUIRED TO SET UP STUDY) 

MD NAME 
NUMBER 

E-MAIL (ONLY SECURE BMC E-MAIL ADDRESS CAN BE USED) FOR RESULTS: 

FAX TO SEND RESULTS: 

LOCATION OR E-MAIL TO SEND INVOICES: 

SCOPE OF WORK (please briefly describe research protocol):  

Two patient identifiers, name and date of birth, are required for each participant sample. No exceptions. 

IRB NUMBER: 
(COPY OF IRB APPROVAL LETTER IS REQUIRED) 

TEST(s) REQUESTED (list each separately - DO NOT LIST PANELS we will group tests in panels as needed) 

NUMBER OF SPECIMENS TO BE DELIVERED TO LAB AT ONE TIME: 

SIGNATURE OF PRINCIPAL INVESTIGATOR: 

RETURN TO: Laboratory Medicine  
670 Albany Street, Room #733  
PHONE: 617-638-7800  
FAX: 617-638-4556  
OR E-MAIL TO: susan.mallardshea@bmc.org  

Susan Mallard-Smith, Laboratory Medicine Office Manager  
(Allow two weeks for processing)