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-Shea, Laboratory Medicine Office Manager**

(Allow two weeks for processing)