**PHARMACY**

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| This form must be completed for all studies which involve pharmaceutical agents.  Please complete all questions and obtain appropriate signature. |

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| Principal Investigator: |  | | | | **REB #** |
| Name of Sponsor: |  | | | | |
| Primary Contact: |  | | | |  |
| Name: |  | | | | Telephone # |
|  |  | | | |  |
| Billing Information: |  | | | |  |
| Name: |  | | | | Telephone # |
| Address: |  | | | | |
| Cost Centre: |  | | | | |
| Study Start Date: | | | Study End Date: | | |
| Project Title: | | | | | |
| Funding: (Please check) | | Funded | | Non funded | |

|  |  |  |
| --- | --- | --- |
| 1. **Extent of support required from Pharmacy Services: (please check)** | | |
| None |  | |
| Clinical support | Please describe: | |
| Investigational product receiving/storage/disposal |  | |
| Dispensing | Individual patient | Stock supply |
| Specialized service | Randomization/blinding | Product formulation development |
|  | Other, please describe: | |
| Specialized product preparation | Please describe: | |
| 1. **Nature of Investigation Product supply:** | C&W supply  Sponsor’s supply  Other (please describe): | |
| 1. **Anticipated number of subjects**: | | |

***Sections below to be completed by pharmacy***

|  |  |  |
| --- | --- | --- |
| **COST ESTIMATE** | |  |
| SERVICE | COST | Comments |
| Protocol Review |  |  |
| Study Set-up fee |  |  |
| Study Maintenance fee |  |  |
| Dispensing fees |  |  |
| Investigational Product Manufacturing Labour cost |  |  |
| Clinical Support |  |  |
| Other |  |  |

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Date Clinical Coordinator, Pharmacy or

Delegate (title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )