CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA

RESOURCE UTILIZATION FORM

PHARMACY

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

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:	
2. **Nature of Investigation Product supply:**	☐C&W supply ☐Sponsor's supply ☐Other (please describe):	
3. **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		

Date

Clinical Coordinator, Pharmacy or Delegate (title: ____________________________)

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