**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 |

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| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )