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 signatures.

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	Production 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: ______________________________)