University of California, Davis
Health System, Sacramento
Department of Pathology and Laboratory Medicine

CLINICAL AND QUALITY RESEARCH (CQR) CQR 001

Please allow at least business 10 days for initial review. The Clinical and Quality Research Team will follow-up if there are any additional questions or concerns. Note, there are certain limitations to some testing resources through the clinical laboratory. Check the Dept. of Pathology Research page for up-to-date information: http://www.ucdmc.ucdavis.edu/pathology/research/index.html. Please return this form to **Hs-Pathresearch@ucdavis.edu.**

A. General Project Information

Study Title: _____

Principal Investigator: _____

IRB Number:_____IRB Expiration Date:_____

Please attach approved protocol and IRB approval letter when available. We understand that IRB number and approval may not be available when this form is first submitted but please circle back and provide this information when it becomes available.

Anticipated start date of study:_____

Study duration (years, months, weeks):_____

How many patients will be enrolled at UC Davis?_____

How many patients will be active at any given time (approximately)?_____

B. What Pathology resources are needed? (please check all applicable)

____ Blood bank
____ Apheresis
____ Clinical Testing (if checked, see Part C)
____ Blood draw: *Frequency per patient*_____
Location: _____
____ Other (*please describe*_____)

C. Clinical Testing performed at UCDMC*

Please list requested labs:_____

_____

On a **per patient** basis, please describe:

Total number of specimens:_____

Testing Frequency (*i.e. 5 samples per week*):_____

_____

Will any of these tests be used for patient care? ◯ yes ◯ no

If yes, which labs tests? _____

**If multiple testing is requested with varying frequencies, please list all tests with the respected frequency. A separate sheet can be added if more room is needed.*

Primary Study Contact (Note: studies requiring research patient testing must provide a reliable contact [24/7 coverage] for reporting of critical laboratory results ***or*** provide a declaration in writing that they decline to receive critical value notifications)

Name: _____

Phone number: _____ **E-mail:** _____

Study Emergency Contact

Name:_____**Phone number:** _____

Electronic signatures accepted.

Study Principal Investigator: _____ _____

Signature **Date**

Study Coordinator (if available): _____ _____

Signature **Date**

FOR CLINICAL AND QUALITY RESEARCH USE ONLY

☐ Valid IRB Protocol and Decision Letter on file with the Clinical and Quality Research Team

☐ Type/Frequency of review determined by Clinical Research Oversight Committee

Type/Frequency: _____

Approval Signatures

FOR CLINICAL AND QUALITY RESEARCH USE ONLY

Clinical Quality Research Associate: _____ _____
Signature Date

Clinical Research Oversight Committee Designee: _____ _____
Signature Date

Quality Assurance and Operations Manager: _____ _____
(for full review studies only) Signature Date