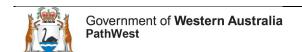


Manual: CRA



CLINICAL TRIALS INFORMATION FORM

CLINICAL TRIALS IN ORM					
Date					
Full Study Title					
Short Title					
(Protocol number)					
Principal Investigator (PI) ONLY ONE PI PER FORM	Contact Email				
Trial Coordinator	Contact Phone Contact Email				
That Goordinator	Contact Phone				
Department/Address					
Expected Start Date	Study Duration				
Recruitment Period					
No. of Subjects to be	No. of Subjects				
screened	to be recruited				
Details of Testing required at each visit	Tests/Protocol must be clearly specified in relation to Standard of Care, Clinical Trials Tests and Central Laboratory Tests (please attach schedule				
required at each visit	if detailed)				
Trial Site/Network TICK ONE BOX ONLY	☐ Armadale Hospital				
PER FORM	☐ Bentley Hospital				
	☐ Fiona Stanley Hospital				
	☐ Fremantle Hospital				
	☐ King Edward Memorial Hospital☐ Osborne Park Hospital☐ Perth Children's Hospital				
	☐ Rockingham Hospital				
	☐ Royal Perth Hospital				
	☐ Sir Charles Gairdner Hospital				
	□ WACHS REGIONAL HOSPITALS				
	please specify:				
Will Phlebotomy be					
Required	□ Yes □ No				
	If yes, please specify PathWest Collection Centre patients will be utilising:				
Will Samples be collected	□ Yes □ No				
outside normal working					
hours (8.30am-4.30pm) for Time Point Test/s	If yes, please provide details:				
TOT THINE FORM TESUS					
1					

Manual: CRA Title: Clinical Trials Information Form

Will Special Handling be required	☐ Yes If yes, please prov	vide details:	□ No	□ No			
Will Special Storage be required	☐ Yes If yes, please prov	vide details:	□ No	□ No			
Will Special Transport be required	☐ Yes If yes, please prov	vide details:	□ No				
	Prepaid Couriers PathWest Staff to shipping Others:		☐ Yes ☐ Yes	□ No □ No			
Will Sample logs be maintained by PathWest	□ Yes		□ No				
Has Ethics Approval been granted	\square Yes \square No If yes, please provide HREC reference number and date of approval:						
Funding Source							
RGS#							
Clinical Trial #							
ACCOUNTING INFORMATION (Following details MUST be provided)							
Accounts to be addressed to	Name						
	Title						
Invoicing	Name						
	Address						
	Email						
If Account sent as	Contact Phone						
Journal -provide Cost centre	Cost Centre						
Business ABN# or Company ACN#							
Name of University &							
Purchase Order No. # Name of Trial			Signaturo		Date		
Coordinator			Signature		Date		

Please email pathwestclinicaltrials@health.wa.gov.au attaching this form and an electronic copy of the study Protocol.

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PathWest will provide pre-printed Clinical Trials Request forms for all research testing, which must be used to ensure appropriate invoicing in line with Research Governance Requirements.

**** Please allow 2 weeks for the production of a Clinical Trials Request form.

Document Number: CRAF618