**Zuckerberg San Francisco General Hospital and Trauma Center**

Department of Pharmaceutical Services – Investigational Drug Service [DPH-ZSFG-Pharmacy-IDS@sfdph.org,](mailto:DPH-ZSFG-Pharmacy-IDS@sfdph.org) (415) 206-6613

Service Request Form and Agreement

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SECTION 1: To be completed by Principal Investigator (PI) or designee** | | | | | | |
| PI Name |  | | | Phone No. | |  |
| Email |  | | | Pager No. | |  |
| Protocol Title |  | | | | | |
| CHR Approval No. |  | | | Exp. date | |  |
| **BILLING INFORMATION** | | | | | | |
| Billing Account No. |  | | | Type (eg UCSF) | |  |
| Billing Address |  | | | | | |
| Contact Person |  | | | Phone No. | |  |
| Email |  | | | | | |
| **MEDICATIONS INVOLVED IN THE STUDY (PLEASE CHECK BOX IF CHEMOTHERAPY AGENT)** | | | | | | |
| **Drug name** | | **Route** | **Person(s) responsible if IDS is not involved** | | | |
| * Chemo | |  |  | | | |
| * Chemo | |  |  | | | |
| * Chemo | |  |  | | | |
| * Chemo | |  |  | | | |
| **PHARMACY SERVICES REQUESTED** | | | | | | |
| * Protocol review * Randomization * Study regimen blinding   + Single blind OR ☐ Double blind * Drug Receiving/Storage/Return * Drug Accountability/Inventory * Drug Preparation/Dispensing/Labeling | | * Maintenance of dispensing records (while study is active) * Maintenance of study records for years after study ends\* * Correspondence with monitors/meetings * Drug procurement ONLY * Others (please specify):   \*Per Pharmacy Policy 8.1, dispensing records will be kept for 7 years after study completion, unless otherwise specified by the sponsor | | | | |
| PI Signature: | | | | | Date: | |

|  |
| --- |
| **SECTION 2: To be completed by IDS** |
| * IRB/CHR-approved protocol ☐ ZSFG Protocol Application Form ☐ For controlled substances: RAPC approval   IDS Fee Estimate *Fee estimates are subject to change upon further review of study materials if necessary*   * Protocol set-up fee: ☐ Annual maintenance fee: * Study close out fee: ☐ FDA audit fee: * Dispensing fee: ☐ Others: |
| IDS Pharmacist Signature/Name/Date: |
| Director of Pharmaceutical Services Signature/Name/Date: |