Attachment C

San Francisco General Hospital Medical Center
Department of Pharmaceutical Services (DPS)
Investigational Drug Service Form

Please complete/sign table 1 and send a copy of the CHR approved protocol to DPS; complete both tables, sign table 2, and send/fax a copy of CHR approved protocol to DPS if the services are required.

Principal Investigator (PI)____________________Phone #____________Pager # ___________Campus Address__________________

Protocol Title____

____ CHR Approval #________________________________ Exp. Date____________

Medications involved in the study (if the drug is chemotherapy agent please specify):

Drug Name	Route	Pharmacy service required	Yes	No	Person responsible for if pharmacy not involved
		Receiving/Storage/Return			
		Accountability/Inventory			
		Prepare/Dispense/Labeling			
		Dispensing Recordkeeping			
		Other			

PI Signature ____ Date ____

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A copy of the protocol is received by the DPS for file. Signature _________________________IDS Pharmacist Date____________

SERVICE REQUEST AND AGREEMENT

Service Requested (please check):

___ Protocol review
___ Randomization
___ Study Regimen Blinding ___Single Blinded or ___Double Blinded
___ Drug Receiving /Storage/Return
___ Drug Accountability/Inventory
___ Drug Preparation/Dispensing/Labeling
___ Maintenance of Dispensing Records
___ Correspondence with Monitors/Meetings
___ Others (e.g., drug procurement, placebo preparation - specify)

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Proposed Financial Reimbursement:
Management Fee (one time charge per study) _________ Preparation/Dispensing Fee ___________/patient or _________________/dose
Others ____
Account Information:
Account No. ____ Type (e.g., UCSF) _________________________

Billing Address ____

Contact Person ____ Phone No. __________________________________

Signature ____ Date _____________________
Principal Investigator

Signature ____ _________________Date ______________________
IDS Pharmacist

Signature ____Date ______________________
Director of Pharmaceutical Services

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