

Manual: CRA



CLINICAL TRIALS INFORMATION FORM

Date					
Full Study Title					
Short Title					
(Protocol number)					
Principal Investigator (PI)	Contact Email				
ONLY ONE PI PER FORM	Contact Phone				
Trial Coordinator	Contact Email Contact Phone				
Department/Address	Contact Filone				
Department/Address					
Expected Start Date	Study Duration				
Recruitment Period	No. of Cubicata				
No. of Subjects to be screened	No. of Subjects to be recruited				
Details of Testing	Tests/Protocol must be clearly specified in relation to Standard of Care,				
required at each visit	Clinical Trials Tests and Central Laboratory Tests (please attach schedule				
	if detailed)				
Trial Site/Network	☐ Armadale Hospital				
TICK ONE BOX ONLY 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:				
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Will Special Handling be required	☐ Yes If yes, please prov	vido dotoilo:	□ No	□ No		
	ii yes, piease prot	viue uelalis.				
Will Special Storage be required	□ Yes		□ No			
	If yes, please prov	vide details:				
Will Special Transport be	□ Yes		□No			
required	If yes, please prov	vide details:		L 110		
	Prepaid Couriers	5	□ Yes	□ No		
	PathWest Staff to shipping Others:	o arrange	☐ Yes	□ Yes □ No		
Will Sample logs be maintained by PathWest	☐ Yes		□ No			
Has Ethics Approval been granted	□ Yes		□ No			
g. u.i.eu	If yes, please provide HREC reference number and date of approval:					
Funding Source						
RGS#						
Clinical Trial #	NO INFORMATION	. /=	L. C. L. MILLOT			
	NG INFORMATION Name	l (Following	g details MUST	be provided)		
Accounts to be addressed to						
	Title					
Invoicing	Name					
	Address					
	Email					
	Contact Phone					
Dusiness ADM# or	Cost Centre					
Business ABN# or Company ACN#						
Name of University &						
Purchase Order No. # Name of Trial			Cianat		Doto	
Name of Trial			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.

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