**San Francisco General Hospital Medical Center Attachment C**

**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  **=================================================================================================**  A copy of the protocol is received by the DPS for file. Signature IDS Pharmacist Date | | | | | |

Service Requested (please check):

Protocol review

Randomization

**SERVICE REQUEST AND AGREEMENT**

Study Regimen Blinding Single Blinded or Drouble 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

IDSFORM

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