

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

Attachment C

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 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

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