Request for VCU Health System Clinical, Nursing and Ancillary Support

Through a partnership with the VCU Health System and VCU, a standardized fee schedule has been developed and implemented. This fee schedule has set standardized rates for both industry and non-industry clinical trials. These are fixed prices that the ancillaries will be required to quote and charge to study teams.

The form below should be completed to request ancillary services from the VCU Health System. This form will assist study teams in gathering quotes from ancillaries for budgetary purposes. For more instructions please go to The Instructions which will provide instructions, samples, and other documents.

PI First Name ________________________________

PI Last Name ________________________________

PI E-mail ________________________________

PI Phone Number ________________________________

PI Fax ________________________________

PI Address (Including Box #) ________________________________

Is there another study contact/coordinator other than the PI?
☐ Yes
☐ No

Study Contact/Coordinator First Name ________________________________

Study Contact/Coordinator Last Name ________________________________

Study Contact/Coordinator E-mail ________________________________

Study Contact/Coordinator Phone Number ________________________________

Study Contact/Coordinator Fax ________________________________

Study Contact/Coordinator Address (Including Box #) ________________________________

Is the PI also the billing contact?
☐ Yes
☐ No

Is the Study Contact/Coordinator also the billing contact?
☐ Yes
☐ No

Billing Contact First Name ________________________________

Billing Contact Last Name ________________________________

Billing Contact Phone ________________________________

Billing Contact E-mail ________________________________

Billing Contact Fax # ________________________________

Billing Contact Address (Including P.O. Box #) ________________________________

Is there a budget negotiator or developer involved other than the above mentioned individuals?
☐ Yes
☐ No

Should this individual be contacted for pricing quotes provided from this request? ☐ Yes ☐ No

Budget Negotiator First Name ____________

Budget Negotiator Last Name ____________

Budget Negotiator Phone ____________

Budget Negotiator E-mail ____________

Budget Negotiator Fax # ____________

Budget Negotiator Address (Including P.O. Box #) ____________

In what department is the clinical trial managed? ____________

Study Information

Project Title ____________

Please use the following flow chart to answer the next question.

Note- Due to a REDCap issue you may not be able to download the attachment. If you need it please e-mail cctrancilreq@vcu.edu

[Attachment: "Federal vs Industry vs Exemption.pdf"]

Type of Project ☐ Non-Industry Clinical Trial ☐ Industry Clinical Trial

Sponsor/Funding Agency ____________

Protocol Number ____________

NCT Number ____________

Estimated Start Date ____________

Estimated End Date ____________

Upper limit target accrual of patients ____________

Lower limit target accrual of patients ____________

Will any patients or study participants be seen, or activities take place, in VCU Health System patient care areas including inpatient units and/or ambulatory clinics, other than CRS North 8? ☐ Yes ☐ No

If patients or study participants will be seen, or activities take place in VCU Health System patient care areas, you must complete the attached form and review with the nurse manager in charge of that space or unit. The form should then be sent to the Nursing Research Advisory Council (NRAC) at NRAC@mcvh-vcu.edu.

Note- Due to a REDCap issue you may not be able to download the attachment. If you need it please e-mail cctrancilreq@vcu.edu

[Attachment: "Research Pre Assessment Form for Units.pdf"]

Has this study received IRB approval? ☐ Yes ☐ No

What is the IRB number? ____________

What date was this approved? ____________

Ancillary Services Needed

Ancillary

- ☐ Anesthesiology/Surgery/NeuroSurgery
- ☐ Audiology
- ☐ Bone Density Scans
- ☐ Cardiology Request Non-Invasive (EKG/Holter/Stress/Echo)
- ☐ Cardiology Request Invasive (Cathlab/EP)
- ☐ Clinical Research Services
- ☐ Devices and Supplies
- ☐ Emergency Room
- ☐ GI Endoscopy
- ☐ Home Care
- ☐ Labor and Delivery
- ☐ Neurophysiology (EEG)
- ☐ OB/Gyn
- ☐ Operating Room
- ☐ Ophthalmology
- ☐ Orthopedics
- ☐ Pathology and Anatomic Pathology
- ☐ Physical, Occupational and Speech Therapy
- ☐ Pulmonary/Respiratory Care
- ☐ Radiology
- ☐ Register a trial and drug management plan without Investigational Drug Service dispensing
- ☐ Request Investigational Drug Services
- ☐ Respiratory Care and Pulmonary Function
- ☐ Renal Dialysis
- ☐ Vascular Lab
- ☐ Other

You have selected "Register a trial and drug management plan without investigational drug service dispensing".

Please go to the following link to complete the Investigational Drug Service Form to complete this request.

Register a trial and drug management plan without IDS dispensing

If the link does not work please copy and paste the following link in a web browser.

http://www.investigationaldrugs.vcu.edu/investigator/registertrial.html

You have selected "Investigational Drug Services".

Please go to the following link to complete the Investigational Drug Service Form to complete this request.

Investigational Drug Services

If the link does not work please copy and paste the following link in a web browser.

http://www.investigationaldrugs.vcu.edu/investigator/requestservices.html

You have selected "Clinical Research Services". Please go to the following link to complete the CRS Intake Form.

CRS Intake Form

If the link does not work please copy and paste the following link in a web browser.

https://redcap.vcu.edu/rc/surveys/?s=vN6Xbg

What is the e-mail of the person that will be submitting/completing these requests? ________________________________

CRS Request

You have selected Clinical Research Services. Please go to the following link to complete the CRS Intake Form.

CRS Intake Form

If the link does not work please copy and paste the following link.

https://redcap.vcu.edu/rc/surveys/?s=vN6Xbg

Radiology Request

You are receiving this survey because you requested ancillary services from the Department of Radiology. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
Radiology Studies/Procedures Requested	__________________________________
Imaging Location (Select all that apply)	☐ Main 3 ☐ Nelson Clinic ☐ Stony Point ☐ ACC ☐ Nuclear Medicine
Does The Study Require the Involvement of a Radiologist (i.e. to provide information not typically found in standard reports, RECIST/WHO reads, CRF completion, protocol oversight)?	☐ Yes ☐ No
If yes, please explain in detail.	__________________________________
Please select any/all items required by the sponsor/protocol. *Please allow two to three weeks for review/completion ^Submit copy of Technical Manual to Radiology	☐ Site Survey/Questionnaire* ☐ QC/Test images to be performed* ☐ Specific technical factors for imaging^ ☐ Anonymized CDs to send data to sponsor ☐ Electronic transmission of images to sponsor ☐ Special training for the techs or radiologists
Indicate type of QC/Test image:	☐ Dummy Scan ☐ Phantom Scan ☐ Other
If Special training for Techs or Radiologists, please describe:	__________________________________

Pathology Request

You are receiving this survey because you requested ancillary services from the Department of Pathology. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.
- ☐ Yes
- ☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Request Instructions

[Attachment: "Directions.pdf"]

Requested services

Does this study involve retrieval of residual samples from the Department of Pathology?
- ☐ Yes
- ☐ No

Please indicate specimen type
- ☐ Serum
- ☐ Plasma
- ☐ Whole Blood
- ☐ Urine

Minimum specimen volume: ______________________________

Storage requirement
- ☐ Room Temperature
- ☐ Refrigerated (~4?C)
- ☐ Frozen at -20?C
- ☐ Frozen at -80?C

Would you like to request additional services other than Specimen Retrieval Services?
- ☐ Yes
- ☐ No

Does this study involve the processing and shipping of samples to a central lab?
- ☐ Yes
- ☐ No

Would you like to request that samples are processed and/or shipped by the CPRS?
- ☐ Yes
- ☐ No

Please indicate the services you would like performed by the CPRS:
- ☐ Specimen Processing
- ☐ Specimen Storage (Room Temperature, Frozen, and/or Ambient > 24 hours)
- ☐ Shipping to Central Laboratory (shipping boxes and airbills must be provided)
- ☐ Other:

Please indicate any other services you would like to be performed by the CPRS: ______________________________

When will the samples arrive in the lab (Check all that apply)
- ☐ Weekdays
- ☐ Weekends
- ☐ Days
- ☐ Evenings
- ☐ Nights

Will the labs be batched?
- ☐ Yes
- ☐ No

Will the samples be frozen?
- ☐ Yes
- ☐ No

Are the samples from:
- ☐ Humans
- ☐ Animals

What species of animal(s)? ______________________________

Will the study use the Clinical Research Services Unit?
- ☐ Yes
- ☐ No

Will patients reside (i.e., >12 hours) in the Clinical Research Services Unit during the study?
- ☐ Yes
- ☐ No

Will the study involve any Blood Bank (Transfusion Medicine)?
- ☐ Yes
- ☐ No

Has the department been contacted?
- ☐ Yes
- ☐ No

Will the study involve any Anatomic Pathology Services?
- ☐ Yes
- ☐ No

Do you need any services in addition to Specimen Processing and/or Shipping Services?
- ☐ Yes
- ☐ No

How are results to be received?
- ☐ Faxed to dedicated fax number
- ☐ Mailed to PO BOX
- ☐ Cerner

What is the fax number? ______________________________

What is the P.O. Box? ______________________________

Please provide the full names of the staff members that should have access to lab results for this trial. ______________________________

Who should be contacted with Panic Values? (24 Hours):
- ☐ Principal Investigator
- ☐ Study contact/coordinator
- ☐ On Call Physician
- ☐ Alternate Contact

Phone number of On Call Physician ______________________________

Pager number of On Call Physician ______________________________

Name of Alternate Contact ______________________________

Phone number of Alternate Contact ________________________________

Pager number of Alternate Contact ________________________________

List laboratory tests required for the study: Please be as specific as possible (i.e., breakdown of Chemistry Panel etc.) ________________________________

Will Emergency Room Staff be expected to draw samples from Emergency Room Patients?

- ☐ Yes
- ☐ No

By selecting yes to the question above you will be e-mailed the Emergency Room request. Please complete it to ensure all aspects of your study are covered.

Document Upload

Specimen Processing/Lab Manual (if applicable)

Signed CPRS Pricing Proposal

Cardiology Request Non-Invasive (EKG/Holter/Stress/Echo)

Please complete the survey below.

Thank you!

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Do you require an EKG?	☐ Yes ☐ No
Do you require an ECHO?	☐ Yes ☐ No
Brief Description of Study:	______________________
Heart Station Studies/Procedures Requested:	______________________
List any Special Reading Requirements (i.e same reviewer for all, extra review, RECIST, etc):	______________________
Will there be more than one procedure required for a given patient?	☐ Yes ☐ No
What is the interval between procedures eg every 3 months, every 6 weeks, etc.	______________________
Will the physician need to provide an Interpretation with a report?	☐ Yes ☐ No
Please provide the physician ID number for billing.	______________________
Does the Sponsor require any of the following?	☐ Site Survey/Questionnaire (upon submission, please allow 2 weeks for review/completion) ☐ QC/Test images to be performed (upon submission, please allow 2-3 weeks for review/completion) ☐ Specific technical factors for imaging (submit copy of Technical Manual) ☐ Anonymized CDs to send data to Sponsor?
Please provide a copy of the ECHO specific protocol only (Please break out the section of the protocol that specifies what ECHO items are needed. Please do not upload the entire protocol).	

Cardiology Request Invasive (Cathlab/EP)

Please complete the survey below.

Thank you!

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Brief Description of Study:	__________________________________

Respiratory Care and Pulmonary Function Request

You are receiving this survey because you requested ancillary services from Respiratory Care and Pulmonary Function. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.
- ☐ Yes
- ☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Request Instructions

[Attachment: "Directions.pdf"]

Is any member of VCU Respiratory Care Services staff a co-investigator on this study?
- ☐ Yes
- ☐ No

What is the co-investigator's name? ________________________

Will the staff member receive salary support from this study?
- ☐ Yes
- ☐ No

Will the VCU respiratory care services department receive financial support?
- ☐ Yes
- ☐ No

What services/testing are being requested?
- ☐ Spirometry Pre Dilator
- ☐ Spirometry Pre and Post Dilator
- ☐ Lung Volume (Plethysmography) w/wo Airway Resist
- ☐ Diffusing Capacity
- ☐ Arterial Blood Gas Puncture (Blood Gas Analysis will need to be requested from Pathology)
- ☐ Bronchoscopy
- ☐ Other

How often will Spirometry Pre Dilator be performed per patient? (i.e. 5 per month, 1 per year, 2 every 6 months) ________________________

How often will Spirometry Pre and Post Dilator be performed per patient? (i.e. 5 per month, 1 per year, 2 every 6 months) ________________________

How often will Lung Volume testing be performed per patient? (i.e. 5 per month, 1 per year, 2 every 6 months) ________________________

How often will Diffusing Capacity be performed per patient? (i.e. 5 per month, 1 per year, 2 every 6 months) ________________________

How often will Arterial Blood Gas Puncture be performed per patient? (i.e. 5 per month, 1 per year, 2 every 6 months) (Blood Gas Analysis will need to be requested from Pathology) ______________________

How often will Bronchoscopy be performed per patient? (i.e. 5 per month, 1 per year, 2 every 6 months) ______________________

Please describe what type Bronchoscopy is needed? ______________________

Do you know the required CPT Codes for the Bronchoscopy?
- ☐ Yes
- ☐ No

What are the related CPT Codes? ______________________

Are there any other special reading requirements?
- ☐ Yes
- ☐ No

What are the special reading requirements? ______________________

Investigational Drug Service

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

You have selected "Investigational Drug Services".

The Investigational Drug Services Request Form is currently under development.

If you have not already done so for this study, please go to the following link to complete the Investigational Drug Service Form to complete this request.

Investigational Drug Services

If the link does not work please copy and paste the following link in a web browser.

http://www.investigationaldrugs.vcu.edu/investigator/requestservices.html

Without IDS Dispensing

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber].

You have selected "Register a trial and drug management plan without investigational drug service dispensing".

The Register a trial and drug management plan without investigational drug service dispensing Form is currently under development.

If you have not already done so for this study, please go to the following link to complete the Investigational Drug Service Form to complete this request.
Register a trial and drug management plan without IDS dispensing

If the link does not work please copy and paste the following link in a web browser.

http://www.investigationaldrugs.vcu.edu/investigator/registertrial.html

Renal Dialysis Request

You are receiving this survey because you requested ancillary services from Renal Dialysis. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.
☐ Yes
☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Request Instructions

[Attachment: "Directions.pdf"]

In what area will this study be done? (Please list all locations) ______________________________

What type of treatment will this be?
☐ CRRT
☐ Hemodialysis

How many days for CRRT? ______________________________

How many days for Hemodialysis? ______________________________

Will the study pay the nurses directly or will the Renal Dialysis be paid directly?
☐ The study will pay the nurses directly
☐ Renal Dialysis will be paid directly

Will there be additional staff training required?
☐ Yes
☐ No

What kind of training will be required? ______________________________

Will this study be using its own equipment or will it be using the equipment of the Renal Dialysis Unit?
☐ Study Equipment
☐ Renal Dialysis Equipment

Will the Renal Dialysis Unit be expected to provide storage space for the study equipment?
☐ Yes
☐ No

Will the patient population be adult or pediatric?
☐ Adult
☐ Pediatric

Physical, Occupational and Speech Therapy Request

You are receiving this survey because you requested ancillary services from Physical, Occupational, and Speech Therapy. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.
- ☐ Yes
- ☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Request Instructions

[Attachment: "Directions.pdf"]

What specific assessments are you requesting? ______________________

Does this include follow up assessments?
- ☐ Yes
- ☐ No

In what time frame will the follow up assessments occur?
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 6 months
- ☐ 9 months
- ☐ 12 months
- ☐ other

Other: ______________________

Are you requesting therapy interventions or treatments?
- ☐ Yes
- ☐ No

What are the therapy interventions or treatments that you are requesting? ______________________

Does this include follow ups?
- ☐ Yes
- ☐ No

In what time frame will the follow ups occur?
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 6 months
- ☐ 9 months
- ☐ 12 months
- ☐ other

Other: ______________________

Where will the assessments/follow ups occur? ______________________

Operating Room Request

You are receiving this survey because you requested ancillary services from the Operating Room. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
Do you require PACE (Preoperative Assessment, Communication, and Education) services?	☐ Yes ☐ No
Which PACE services do you require?	☐ Pre-anesthesia screening ☐ MRSA Screening ☐ Lab Work (please specify) ☐ EKG ☐ Patient/Family Education (regarding surgery process)
If Lab work, please specify	__________________________
What preoperative services do you require?	☐ MRSA Screening ☐ Lab Work ☐ X-Rays ☐ EKG's ☐ History and Physical ☐ Anesthesia Assessment ☐ Other
Other:	__________________________
Are there labs that need to be drawn on the day of surgery?	☐ Yes ☐ No
When will the labs need to be drawn?	☐ Preop ☐ Intraop ☐ Postop
What labs need to be drawn?	__________________________
Will there be specimens collected by the surgical team?	☐ Yes ☐ No
What specimens will be collected by the surgical team?	__________________________
Where will the specimens be sent for processing?	__________________________

Are there any specific processes to be followed postoperatively?

☐ Yes
☐ No

What specific processes need to be followed postoperatively? __________________________________

Comments/Notes __________________________________

Orthopedics Request

You are receiving this survey because you requested ancillary services from Orthopedics. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
Describe the surgical procedure that is needed?	__________________________________
Do you have any specific questions?	__________________________________

OB/Gyn Request

You are receiving this survey because you requested ancillary services from the Department of OB/Gyn. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
What services do you need?	☐ Ultrasound ☐ Other
What services are you requesting?	__________________________________
What will be the location of the service?	☐ Stony Point ☐ Nelson Clinic
Do you have any specific questions?	__________________________________

Home Care Request

You are receiving this survey because you requested ancillary services from Home Care. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
What activities and/or procedures are you requesting?	______________________
What locations will be needed?	☐ Patient Home ☐ Nursing Home ☐ Inpatient ☐ ACC ☐ Other
Other:	______________________

Vascular Lab Request

You are receiving this survey because you requested ancillary services from the Vascular Lab. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
What vascular exam(s) are you requesting?	______________________
Will you need a final read?	☐ Yes ☐ No
Will there be a core lab reading the vascular exam?	☐ Yes ☐ No
Does the core lab require the Vascular Technologist to be certified?	☐ Yes ☐ No
Who is the core lab?	______________________
Who is the contact for the core lab?	______________________
Does the core lab have specific forms that the vascular lab will be expected to complete?	☐ Yes ☐ No
Please upload the additional forms.	
Please upload the additional forms.	
Please upload the additional forms.	
What will be the method of delivery for the exams?	☐ Electronic upload ☐ Mail ☐ Exam's will be given to VCU Coordinator
What is the core lab's mailing address?	______________________

GI Endoscopy Request

You are receiving this survey because you requested ancillary services from the Department of OB/Gyn. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "ancinstructions.pdf"]	

Please note, you need to submit a pharmacy request for all endoscopic procedures.

What type of procedures are you requesting?	☐ Upper Endoscopy ☐ Upper Endoscopy with biopsy ☐ Colonoscopy ☐ Colonoscopy with biopsy ☐ Flexible Sigmoidoscopy ☐ Flexible Sigmoidoscopy with biopsy ☐ Upper endoscopic ultrasound (EUS) ☐ EUS with fine needle aspiration ☐ Lower endoscopic ultrasound ☐ Lower endoscopic ultrasound with fine needle aspiration
Will this requre video recording?	☐ Yes ☐ No
Will the video equipment be provided by the study sponsor?	☐ Yes ☐ No
Will special training be required?	______________________________

Labor and Delivery Request

You are receiving this survey because you requested ancillary services from Labor and Delivery. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
What services/procedures do you need from Labor and Delivery?	______________________
What time frame will be needed for data/sample collection?	☐ Monday through Friday 8 to 5 ☐ Saturday 8 to 5 ☐ Sunday 8 to 5 ☐ Monday through Friday 24 hours ☐ Saturday 24 hours ☐ Sunday 24 hours
How long is the sample expected to be stored?	☐ Sample Cannot be Stored ☐ 12 Hours ☐ 24 Hours

Emergency Room Request

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.

☐ Yes
☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Request Instructions

[Attachment: "Directions.pdf"]

The Emergency Room Request Form is currently under development. Please contact Kathy Baker (kbaker@mcvh-vcu.edu) for pricing. You can click submit to notify Kathy Baker who will be able to see a copy of your submitted form but please e-mail her as well. If you have questions or need assistance please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

Anesthesiology/Surgery/NeuroSurgery Request

You are receiving this survey because you requested ancillary services from Anesthesiology/Surgery/NeuroSurgery. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.
- ☐ Yes
- ☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Service Instructions

[Attachment: "Directions.pdf"]

Anesthesiology/Surgery/Neurosurgery Request

What type of anesthesia do you need?
- ☐ General
- ☐ Regional blocks
- ☐ Spinal
- ☐ Epidural
- ☐ Mac IV sedation
- ☐ Other

Where will the anesthesia be administered?
- ☐ Main OR
- ☐ Main PACU
- ☐ ACC OR
- ☐ ACC PACU
- ☐ PSU
- ☐ CPU
- ☐ Interventional Radiology
- ☐ Labor & Delivery
- ☐ EP Lab
- ☐ Cath Lab
- ☐ Other

Please provide 5 to 6 similar patients who have had this procedure or a like procedure in the recent past including their name, MRN and DOS. __________________________

To what procedure/CPT/ASA code is __________________________

What is the expected average anesthesia time? (e.g. 1 hour, 2 hours, etc.) __________________________

Do you know the Surgeon(s) and/or Anesthesiologist(s) that will be performing the procedure(s)? Please select all that apply.
- ☐ Anesthesiologist
- ☐ Surgeon

Who is the Anesthesiologist(s) who will be performing the procedure(s)? (list all individuals) __________________________________

Who is the Surgeon(s) who will be performing the procedure(s)?(list all individuals) __________________________________

Is the Surgeon who will be performing the procedure(s) receiving direct effort through the trial/protocol through VCU (Direct Salary Support in the form of Effort)? __________________________________

What are the core morbidities of the average patient? __________________________________

Devices and Supplies Request

You are receiving this survey because you requested ancillary services from Devices and Supplies. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
Do you have any specific questions?	______________________
Who is the vendor?	______________________
What devices/supplies are you requesting?	______________________
Do you have a quote from the vendor?	☐ Yes ☐ No
If yes, please attach the quote	
Please supply the accounting unit for those responsible for the payment of the device/supply	______________________
When will this device/supply be needed?	______________________

Stem Cell Lab Request

You are receiving this survey because you requested ancillary services from the Stem Cell Lab. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.

☐ Yes
☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Service Instructions

[Attachment: "Directions.pdf"]

Do you have any specific questions? ______________________________

Neurophysiology Request

You are receiving this survey because you requested ancillary services from Neurophysiology. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Ancillary Request Instructions	
[Attachment: "Directions.pdf"]	
EEG Studies/Procedures Requested	______________________
What procedures are you requesting?	☐ Routine EEG ☐ Prolonged EEG ☐ Ambulatory EEG ☐ Sleep deprived EEG ☐ EMG ☐ Evoked potentials
What is the indication for the test?	______________________
The procedures will be performed on	☐ Adults ☐ Children
Do you want the study interpreted?	☐ Yes ☐ No
Are their any precautions that the team should be aware of? (i.e. combative, type of isolation)	☐ Yes ☐ No
What are the precautions?	______________________

Other Request

You are receiving this survey because you requested other ancillary services. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above. ☐ Yes ☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

Ancillary Request Instructions

[Attachment: "Directions.pdf"]

What other Ancillary service do you need? (please only list one) ______________________

What services do you need from [other_other1]? ______________________

Do you need another service? ☐ Yes ☐ No

What other Ancillary service do you need? (please only list one) ______________________

What services do you need from [other_other2]? ______________________

Do you need another service? ☐ Yes ☐ No

What other Ancillary service do you need? (please only list one) ______________________

What services do you need from [other_other3]? ______________________

Do you need another service? ☐ Yes ☐ No

What other Ancillary service do you need? (please only list one) ______________________

What services do you need from [other_other4]? ______________________

Bone Density Scans Request

You are receiving this survey because you requested ancillary services from Bone Density Scans. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No

PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu

The Bone Density Scans Request Form is currently under development. Please contact Katherine Mulloy (kmulloy@mcvh-vcu.edu) for pricing. You can click submit to notify Katherine Mulloy who will be able to see a copy of your submitted form but please e-mail her as well. If you have questions or need assistance please contact cctrancilreq@vcu.edu.

Please reference request number [requestnumber] in any and all correspondence.

Audiology

You are receiving this survey because you requested ancillary services from Audiology. Complete the survey below to send a pricing request and allow two (2) weeks for processing. If you do not hear back within two (2) weeks, or if you have any questions or concerns, please contact cctrancilreq@vcu.edu.

You must select SUBMIT for your survey to be received/processed.

This form is for Dr. [pilastname] Ancillary request form regarding the protocol titled [projecttitle] with a protocol number of [protocolnumber]

Please confirm that you are completing this for the study listed above.	☐ Yes ☐ No
PLEASE STOP AND CONTACT CCTRAncilReq@vcu.edu	
Do you want a diagnostic test or a screening? (Note: A screening test will only tell you if further testing is needed. A diagnostic test will inform you if it is a permanent or temporary hearing problem.) NOTE: You can select either to see a description of the services provided. Please ensure that when submitted the form you only select the services needed.	☐ Diagnostic ☐ Screening

Diagnostic audiological testing not only determines hearing thresholds on the date of testing, but the etiology of any noted hearing loss (inner ear vs middle ear disorders). Screenings only determine hearing thresholds on the date of testing --no further diagnostic testing is provided. Please click on both "Diagnostic" and "Screening" to read the descriptions of the types of tests done for each purpose and select "Screening" or "Diagnostic".

Testing will include visual reinforcement audiometry (VRA) using sound field testing or earphones (supraural or insert) for participants approximately 6 to 30 months old, play audiometry with earphones for participants approximately 30 months to 5 years (developmental age), and standard audiometry for those approximately 5 to 18 years of age. The specific test procedure(s) used for each participant is left to the discretion of the audiologist. For young infants and for special populations where behavioral audiometry cannot be completed, otoacoustic emissions testing will be performed.

Audiometric responses will be measured from 500 - 6000 Hz for VRA and 250 to 8000 Hz for play and standard audiometry. When performing VRA, it is not necessary to test below 15dBHL. Bone conduction testing shall be performed if air conduction test results are elevated.

Tympanometry will be performed with all audiometry testing where rule out testing is desired. This is to rule out middle ear dysfunction in cases where changes in hearing are noticed.

Abnormal hearing sensitivity will be defined as hearing threshold levels >25 dB HL for VRA (visual reinforcement audiometry) at any frequency (500-6000Hz) and >20 dB HL for play or standard audiometry at any two frequencies (250-8000Hz) in either ear.

Do you want testing of middle ear dysfunction in cases of hearing change? Some hearing losses are not inner ear problems but may be temporary due to ear infections.	☐ Yes ☐ No

Testing will include visual reinforcement audiometry (VRA) using sound field testing or earphones (supraural or insert) for participants approximately 6 to 30 months old, play audiometry with earphones for participants approximately 30 months to 5 years (developmental age), and standard audiometry for those approximately 5 to 18 years of age. The specific test procedure(s) used for each participant is left to the discretion of the audiologist. For young infants and for special populations where behavioral audiometry cannot be completed, otoacoustic emissions testing will be performed.

Audiometric responses will be measured from 500 - 6000 Hz for VRA and 250 to 8000 Hz for play and standard audiometry. When performing VRA, it is not necessary to test below 15dBHL.

Tympanometry will be performed with all audiometry testing where rule out testing is desired. This is to rule out middle ear dysfunction in cases where changes in hearing are noticed.

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Testing will include visual reinforcement audiometry (VRA) using sound field testing or earphones (supraural or insert) for participants approximately 6 to 30 months old, play audiometry with earphones for participants approximately 30 months to 5 years (developmental age), and standard audiometry for those approximately 5 to 18 years of age. The specific test procedure(s) used for each participant is left to the discretion of the audiologist. For young infants and for special populations where behavioral audiometry cannot be completed, otoacoustic emissions testing will be performed.

Audiometric responses will be measured from 500 - 6000 Hz for VRA and 250 to 8000 Hz for play and standard audiometry. When performing VRA, it is not necessary to test below 15dBHL.

Abnormal hearing sensitivity will be defined as hearing threshold levels >25 dB HL for VRA (visual reinforcement audiometry) at any frequency (500-6000Hz) and >20 dB HL for play or standard audiometry at any two frequencies (250-8000Hz) in either ear.

Is hearing being monitored to rule out hearing loss related to medical treatment?
- ☐ Yes
- ☐ No

What is the age of the participant at time of consent?
- ☐ Under 6 months
- ☐ 6 to 30 months
- ☐ 30 months to 5 years
- ☐ 5 years to 18 years
- ☐ Over 18 years

How many participants are expected to be enrolled under 6 months of age? ________________________________

How many participants are expected to be enrolled 6 to 30 months of age? ________________________________

How many participants are expected to be enrolled 30 months to 5 years of age? ________________________________

How many participants are expected to be enrolled 5 to 18 years of age? ________________________________

How many participants are expected to be enrolled over the age of 18? ________________________________

Are the over 18 participants expected to be developmentally delayed?
- ☐ Yes
- ☐ No

In some cases there are young children and developmentally delayed adults who can't/won't cooperate for any behavioral test. In that case, if we have obtained some behavioral test results but could not complete the test, do you want the partial results or would you like audiology to do a screening if they can't get diagnostic tests?
- ☐ Yes, if you have obtained some behavioral test results but could not complete the test, we want the partial results.
- ☐ Yes, we would like like audiology to do a screening if they can't get diagnostic tests

Other questions or comments ________________________________