This form should be utilized by investigation when requesting use of Pathology lab services which will not be funded by a sponsored project. This includes but is not limited to investigator initiated projects and use of discretionary funding. Submission and approval of this request will generate a service agreement for your specific project. Please submit completed forms via email to [labresearchcoordinator@choa.org](mailto:labresearchcoordinator@choa.org)

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Study Title:** | | | | | | | |
| **IRB #:** | | | **IRB Approval Date:** | | | **IRB Exp. Date:** | |
| **Project Start Date:** | | |  | | |  | |
| **Contact Information:** | | | | | | | |
| Research Manager: | | | | | | | |
| Principal Investigator Name: | | | | | | | |
| Address: | | | | | | | |
| City: | | State: | | ZIP: | | | |
| Phone #: | | Email: | | | | | |
| Financial Contact Name (if different than above): | | | | | | | |
| Phone #: | | Email: | | | | | |
| **Billing Information:** | | | | | | | |
| Type of funding (Circle all that apply): | | Federal | | Industry | Department | | Other:\_\_\_\_\_**X\_\_\_\_\_** |
| Sponsor: | | | | | | | |
| Project/Activity Number: | | | | | | | |
| Billing Address: | | | | | | | |
|  | Address: | | | | | | |
| City: | State: | | | ZIP: | | |
| **Shipping Information:** | | | | | | | |
| FedEx/UPS Account #: | | | | |  | |  |
| Attention: | | | | Institution: | | | |
| Address: | | | | | | |  |
| City: | | State: | | ZIP: | | |  |
| Contact Name (if different than above): | | | | | | |  |
| Phone #: | | Email: | | | | |  |
| **Specimen Processing Information:** | | | | | | | |
| *The Histology Department of Children's Healthcare of Atlanta, under the leadership of Dr. Beverly Rogers, provides histology services to Research Investigators. These services include routine histology, frozen section preparation, special stains and immunohistochemistry. The Histology Department serves as a partner to Research investigators, offering pre-processing instruction as well as basic Histology "know-how".*   * **Turn-Around-Time:** Routine services average a one-week turn-around-time from date of submission * **Submission:** All tissue samples submitted for routine processing must be pre-dissected and submitted in labeled tissue cassettes. | | | | | | | |



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| --- | --- |
| **Submitted Material Notes:** | |
|  | |
| **Signatures:** | |
| Requestor: | Date: |
| Pathology Manager Approval: | Date: |
| Lab Director Approval: | Date: |
| Histologist: | Date: |
| **Additional Comments:**  **For Histology Lab Use Only:** |  |
| Completion Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Delivered to Research Coordinator/Ref Lab: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |