**Pro-forma for Laboratory Medicine – Flow Cytometry Immunophenotyping and Molecular Registration**

v1.2 22.MAR.2023

R&D Number:       Date of Discussion:

*This form should be completed and agreed with Ulrika Johansson,* *Ulrika.Johansson@UHBW.nhs.uk*  *in conjunction with the study protocol. The form should then be sent electronically to* *ResearchApprovals@UHBW.nhs.uk*

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| **Study Title:**  |
| **Principal Investigator (PI) at UHBW:**      Tel:       | **Point of Contact (PoC) at UHBW:**      Tel:       |
| **Sponsor:** |       | **Funding organisation:**  |       |
| Is this a commercially sponsored study? | [ ]  Yes | [ ]  No | How will the costs outlined below be met?       |
| Estimated study start date (at this site):      /     /      | Projected study end of recruitment date:      /     /     Projected end of support department involvement date:      /     /      |
| Do the current negotiations relate to: | [ ] [ ]  | Feasibility (e.g. for funding application or sponsorship request)Trust R&D Approval | Estimated number of participants:       |
| Does this study require blood sciences? | [ ] [ ]  | YesNo | If yes has an appropriate proforma been completed? | [ ] [ ]  | YesNo |

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| **Test\*** | **Cost per unit** **(if above routine care)***To be completed by Lab Medicine* | **Cycle / Visit\*\*** |
|  |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
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|  | **Total Cost per Cycle / Visit:** |       |       |       |       |       |       |       |       |       |       |

\*Please record all lab tests to be done for the protocol, whether part of routine clinical care, or required in addition to routine clinical care.

\*\*Please specify for each Cycle or Visit if each parameter is considered routine care (RC) or over and above routine care (X) in the boxes provided.

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| **Any Special Arrangements/Requirements (e.g. time constraints, remuneration, storage requirements) should be indicated below. Trust Approval for this research study will be based on the information as provided:** |
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| **Resource Authorisation**To be completed by Ulrika Johansson. The form may either be signed or returned via email from the signatory’s UHBW email account |
| **Feasibility Request:** I confirm that the resource requirements for this study are reasonable and the costing information can be included in applications. If this study goes ahead in this form it is likely to be supported by Laboratory Medicine.Not Applicable [ ]  I agree [ ]  I do not agree [ ]  Date:      /     /      |
| **R&D Approval:** Laboratory Medicine will support this study based on the information outlined aboveNot Applicable [ ]  I agree [ ]  I do not agree [ ]  Date:      /     /      |
| **Name:** | **Signature:** |