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| **CLINICIAN’S/RESEARCHER’S REQUEST FORM FOR SAMPLE ANALYSIS /BIOBANK STORAGE/RESEARCH PURPOSES** |
| Patient’s First Name: Last Name:  |
| Age:  | MRN:/ID No.: |
| Patient National ID/Iqama: | Hospital/Institution’s Name: |
| Nationality: | Name of Condition : |
| Male: Female: | Number of Samples: |
| Marital Status: | Sample Collection Date: Time: am pm |
| Physician Name & ID: | Date Sample Sent to IRMC: |
| Department: | Name of Laboratory: |
| Specimen collected by:   |
| **For Research Purposes** |
| Researcher’s Name: |
| Protocol Title: |
| IRB Approval Number: |
| Sample Collection Consent Form attached: □ Yes  |
| Scheduled Procedure Date: |
|  |
|  **TYPE OF SAMPLE OR SPECIMEN**  |  **TYPE OF TEST/ANALYSIS**  |
| □ Amniotic Fluid□ Cord Blood□ Chronic Villus Sample□ Skin□ Tissue □ Urine/Stool□ Saliva/ Hair/ Nail□ Peripheral BloodOther (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Molecular Genetic Study □ Infectious disease (Bacterial Test /Viral Test ,Parasites )□ Inflammatory Disease test (Serology Test )□ Biochemical Assay□ Radio immune Assay□ Scanning Electron Microscope (SEM) /Transmission Electron Microscope □ □Histopathology/cytology/hematology/Immunohistochemistry□ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Please specify required Test:**  |
| **Sample for** □ Analysis Purpose only □ Analysis & Biobank storage □ Analysis, Biobank storage & Research□ Biobank storage & Research Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **Reasons For Test :** |
| **Patient Symptoms:** |
| Dear IRMC,I am submitting patient sample(s) for **Analysis /biobank storage/Research Purposes at IRMC**. The National committee of Bioethics (NCBE)& Standing Committee for Research Ethics on Living Creatures(SCRELC) based bioethics policy and procedures have been clearly explained to patient in detail. I declare that the collected sample(s) is based on the NCBE and SCRELC rules and regulation. *\*Please strikeout the options not approved by the patient.*  |
| **Name and signature of Physician:****Department:****Date:****Laboratory Medical Director:****Date:****Laboratory Supervisor:****Date:****Laboratory Section Head:****Date:****Patient’s Name and Signature:****Date:****Parent’s Name and Signature :****Date:** |
| **IRMC Office Use** |
| IRMC File No. |
| Reason for rejecting Specimen (If applicable): Date Rejected:Date Physician notified:Person notifying Physician: |
| Liaison Office Director’s Name:Signature with date: |
| Biobank Office Director’s Name: Signature with date: |
| Head of the Department’s Name:(Sample Analyzing department)Signature with date: |
| Researcher’s Name: Pathologist’s Name:Signature with date: Signature with date: |
| Dean of IRMC Signature with date: |

*Note: All* ***sample analysis******biobank storage and research purpose method has to be based on the*** *NCBE and SCRELC guidelines.*

*All parties involved should maintain confidentiality/privacy of the patient.*

*All parties should be aware of and follow NCBE and SCRELC guidelines.*

*If the sample is used for Biobank storage and research purposes, the patient should complete the consent form (attached).*

*Based on Article 20.1-20.6, all parents of minors must sign this form on behalf of the minors donating samples*

*For more information*

[*http://www.kacst.edu.sa/eng/Maarifah/Policies/Documents/Research%20Bioethics%20Regulations.pdf*](http://www.kacst.edu.sa/eng/Maarifah/Policies/Documents/Research%20Bioethics%20Regulations.pdf)

[*https://www.uod.edu.sa/sites/default/files/resources/implementing\_regulations\_0.pdf*](https://www.uod.edu.sa/sites/default/files/resources/implementing_regulations_0.pdf)