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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 Blood  Other (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)