



جامعة الإمام عبد الرحمن بن فيصل
IMAM ABDULRAHMAN BIN FAISAL UNIVERSITY
معهد الأبحاث والاستشارات الطبية
Institute for Research and Medical Consultations

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: <input type="checkbox"/> Yes
Scheduled Procedure Date:

TYPE OF SAMPLE OR SPECIMEN	TYPE OF TEST/ANALYSIS
<input type="checkbox"/> Amniotic Fluid	<input type="checkbox"/> Molecular Genetic Study
<input type="checkbox"/> Cord Blood	<input type="checkbox"/> Infectious disease (Bacterial Test /Viral Test ,Parasites)
<input type="checkbox"/> Chronic Villus Sample	<input type="checkbox"/> Inflammatory Disease test (Serology Test)
<input type="checkbox"/> Skin	<input type="checkbox"/> Biochemical Assay
<input type="checkbox"/> Tissue	<input type="checkbox"/> Radio immune Assay
<input type="checkbox"/> Urine/Stool	<input type="checkbox"/> Scanning Electron Microscope (SEM) /Transmission
<input type="checkbox"/> Saliva/ Hair/ Nail	Electron Microscope <input type="checkbox"/>
<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Histopathology/cytology/hematology/Immunohistochemistry
Other	<input type="checkbox"/> Other (Specify): _____
(Specify): _____	Please specify required Test:

To get the application (IRMC.06) in word
scan the following barcode:





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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:

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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>

https://www.uod.edu.sa/sites/default/files/resources/implementing_regulations_o.pdf

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