**Research Request for Surgical/ Interventional Radiology/ Endoscopy Services**

Requestor:

Date of Request: Click or tap to enter a date.

1. **General Study Information** *(To be completed by: Research Development Coordinator)*

Service Line/Specialty Area:

Protocol Title:

PI:

Other participating surgeons operating under the oversight of PI:

IRB #:

Is the Corewell Health Research Department coordinating this study? [ ]  Yes [ ]  No

Where is the procedure occurring? [ ]  OR [ ]  IR [ ]  Endoscopy [ ]  Other: \_\_\_\_\_\_\_\_\_

Will Anesthesiology Services (WMA) be required? [ ]  Yes [ ]  No

Site(s)/location(s) where surgical services is being requested:

**Main Study Contact Name:**

*[Note: This clinical research team member will notify Surgical Services of newly enrolled patients to assure charges drop correctly. See Section 5 for details on the communication plan for this study.]*

Email:

Phone:

**Study Sponsor:**

Main Sponsor Contact Name:

Email:

Phone:

**Projected Start Date:** Click or tap to enter a date.

**End Date:** Click or tap to enter a date.

1. **Device/Procedure Information** *(To be completed by: Research Development Coordinator)*

What is/are the surgical procedure name(s) in which this product will be used:

Is the device FDA approved for the proposed use? [ ] Yes [ ] No

Is this procedure new to SH?

 [ ]  Yes, never been performed here.

 [ ]  No

Is this device new to SH?

 [ ]  Yes\*

 [ ]  No

*\*If ‘yes’ is selected above, and the device is not investigational or being provided by the sponsor, the Research Development Coordinator should reach out to a sourcing specialist for assistance with device/product procurement.*

Projected number of subjects at each surgical location:

What is the method of delivery to the procedure room?

Are there additional staff or facility needs required for this study?

[ ] Yes, explain

[ ] No

Will there be sponsor representatives or other Non-Corewell Health Staff members needing to be present during the cases? [ ] Yes [ ] No

If yes, list:

Sponsor Representative Name(s):

Email/s:

1. **CDM Set-up** *(To be completed by: Research Finance)*

*[Note: If Research Finance doesn’t have the ability to complete this section, share the incomplete form with surgical*

*services to put Research Team in touch with revenue integrity and/or appropriate clinical leaders. They will be able to assist with completion of this section.]*

Is this a chargeable item? [ ] Yes [ ]  No

 Should this item be charged to the patient? [ ] Yes [ ]  No

Revenue code:

Price:

IDE #:

CPT/HCPCS:

Description of CDM:

1. **Operational Information** *(To be completed by: Research Finance)*

*[Note: If Research Finance doesn’t have the ability to complete this section, share the incomplete form with surgical*

*services to get in touch with clinical leaders in the appropriate space. They will be able to assist with completion of this section.]*

What will be covered by the sponsor (specify)?

What will be covered by the patient/insurance (specify)?

Will Surgical Services be responsible for purchasing devices? [ ] Yes [ ] No

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Number of Devices / Products to be Acquired | PO # | Catalog # | Model # | Description | Cost | Chargeable Y/N |
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1. **Communication Plan** *(To be completed by: Research Development Coordinator)*

When a new patient is enrolled in the study, communication from the Research Team will occur according to the following plan:

Communication sent as: [ ] Secure Email [ ] Other (please specify):

Will provide this Request form and the following information:

|  |
| --- |
| *Patient name, Date of Service, MRN (\*send email with “[secure]” in subject line)* |
|  |
|  |

Send from: *[Insert name of Primary Clinical Coordinator]*

Send to: *‘Surgical – Research Request’* group

 *At this point, Research Finance will sign off and date section 6 below, and return form to Research Development team member. RD team member will send electronic protocol with this request form and any other applicable information to the ‘Surgical – Research Request’ group.*

1. **Sign-off Approvals (To be completed by: Research Finance, Surgical Services & Revenue Department)**

[ ]  Reviewed by Spectrum Health Research Finance

Date of Review:

Research Finance contact(s):

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[ ]  Reviewed by Spectrum Health Surgical Services, Clinical Staff

Date of Review:

Surgical Services contact(s):

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[ ]  Reviewed by Spectrum Health Interventional Radiology Services, Clinical Staff

Date of Review:

Surgical Services contact(s):

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[ ]  Reviewed by Business Operations, Dept. Based Revenue Coordinators

Date of Review:

Revenue Coordinator contact(s):

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[ ]  Reviewed by Revenue Integrity

Date of Review:

Revenue Integrity contact(s):