



PHARMACY

This form must be completed for all studies which involve pharmaceutical agents.
Please complete all questions and obtain appropriate signature.

Principal Investigator:

REB #:

Name of Sponsor:

Study Start Date:

Study End Date:

Project Title:

1. Extent of support required from Pharmacy Services (please check):

- None
- Inventory control/record keeping
- Protocol review
- Clinical support
- Individual patient dispensing: inpatients outpatients
- Specialized services: randomization blinding
- Specialized product preparation: sterile product non-sterile product

2. Nature of Drug Supply:

- C&W supplies
- Supplied by sponsor
- Other (please describe):

3. Number of study patients:

4. Resource Budget:

Please note that this estimate includes only the phase(s) of the trial as described in the project title. A separate form is required for any extension of the original project.

ESTIMATE		COMMENTS
DESCRIPTION	COST	
Administration		
Annual study maintenance fee		
Drug Supplies		
Other Supplies and Equipment		
Dispensing Fees/ Labour cost		
Clinical Support		
Other		
TOTAL		

_____ Date

_____ Director, Pharmacy (or delegate)