The DAF form determines what patient care procedures, professional, and technical fees are required. It requires approval of each department providing procedures/services to ensure that the department can provide those services and the procedures/services are feasible. This form also will serve as approval and commitment to participate from the ancillary department. This form must be completed and signed by the appropriate department managers, and submitted with the ancillary budgets to the Children’s research administrator for routing with the proposal package through Office of Sponsored Programs.

Date Requested: 02/15/2017

|  |  |  |
| --- | --- | --- |
| **Study Name:** |  | |
| **Short Study Name:** | |  |
| **Principal Investigator Name:** | |  |
| **Study Sponsor or Funding Source:** | |  |
| **In-patient and/or Out-patient Study:** | |  |
| **Projected Start Date:** | |  |
| **Projected End Date:** | |  |
| **Coverage Analysis:** | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is the study being conducted at a CHOA facility?**  If other or private practice, list location of study site**:** | Egleston | Scottish Rite | Hughes Spaulding | Marcus |

|  |  |
| --- | --- |
| **Projected # of Subjects:** |  |
| **Main Contact / Study Coordinator:** |  |
| **Address:** |  |
| **Phone:** |  |
| **Email:** |  |
| **Other Contact Info:** |  |
| Provide a clear synopsis of specific impact on ancillary departments: | |
| **\*\* Please note that technical procedures or fees may have accompanying professional fees. Prices must be negotiated with each practice. \*\*** | |
| 1. **Does Study involve Investigational Pharmacy Services**?   Date Requested:  Pharmacy Approval: | **Yes**  **No**  Please contact [Jim Rhodes](mailto:idsrx@choa.org), or [Jane Chen](mailto:idsrx@choa.org) Investigational Pharmacist (404-785-1281), and provide copy of protocol with this request form for review and budget     Signature |
| 1. **Pediatric Research Center?**   Date Requested:  PRC Approval: | **Yes  No**  Please contact [Stephanie Meisner](mailto:stephanie.meisner@choa.org), PRC Manager (404.785.6453), and provide a copy of protocol with this request form for review and budget  For complete instructions on how to process your proposal through CTSA Research Committee at Emory and Children’s contact [Stephanie Meisner](mailto:stephanie.meisner@choa.org)        Signature |
| 1. **Laboratory Procedures and Services?** **Yes  No**  |  |  |  | | --- | --- | --- | | Research Processing Laboratory/Advanced Diagnostics | Yes | No | | Histology/ Pathology | Yes | No | | Microbiology/ Virology | Yes | No | | Chemistry And Hematology | Yes | No | | Blood Bank | Yes | No | | Phlebotomy | Yes | No |   *If* ***“yes”*** *to any of the above questions, list details of the procedures/services and provide copy of protocol for review and budget to:* [*labresearchcoordinator@choa.org*](mailto:labresearchcoordinator@choa.org)*.*  *For additional questions and inquiries, please contact:* [*labresearchcoordinator@choa.org*](mailto:labresearchcoordinator@choa.org)   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Tests Requested (List individually)** | **CPT Code** | **EAP Code** | **Research Price**  **(completed by lab)** | **# of Tests Per Patient** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   To add rows: right click on the table and select “Insert”  Date Requested:  *Laboratory Managers:*   |  |  | | --- | --- | | Medical Director, **Dr. Beverly Rogers** | Research Processing, **Heather MacDonald** | | Histology/ Pathology, **Carla Shoffeitt** | Microbiology/ Virology, **Jonelle McKey** | | Chemistry And Hematology (Egleston) –  **Maria Ana Atuan** | Chemistry and Hematology (Scottish Rite) –  **Sandra Estelle** | | Blood Bank Services, **Shannon Pahz** | Lab Research Coordinator, **Cherie Lumpkin and/or Bethany Watson** | | Support Services, **Maria Ana Atuan** |  |  |  |  | | --- | --- | | 1. **Cardiovascular Imaging Research Core?**   Date Requested:  CIRC Approval: | **Yes  No**  Please contact with [Heather Friedman](mailto:Heather.Friedman@choa.org), CIRC manager, and provide copy of protocol with this request form for review and budget        Signature | | 1. **Rehabilitation Services?**   Date Requested:  Rehab Approval: | **Yes  No**  Please contact with [Susannah Kidwell](mailto:susannah.kidwell@choa.org),  Director of Rehabilitation Services, and provide copy of protocol with this request form for review and budget        Signature | | 1. **Pediatric Procedural Sedation Services?**   Date Requested:  Pediatric Procedural Sedation Services Approval: | **Yes  No**  Egleston – Contact [Dr. Pradip Kamat](mailto:Pradip.Kamat@choa.org)  Scottish Rite – Contact Pediatric Emergency Medical Assoc., [Dr. David Werner](mailto:david_werner@pema-llc.com)        Signature | | 1. **Radiology Services? Yes  No**   List name and CPT code for each scan or procedures:  Date Requested:  Please contact [Victoria Allen](mailto:victoria.allen@choa.org), Senior Research Coordinator for Egleston and Scottish Rite; and include the protocol with this request form for review and budget.  Radiology Approval:      Signature: Date: | | | 1. **Other Departments? Yes  No**   Meet with the manager of each service line for costs and approval. Contact the Office Of Sponsored Programs (<mailto:osp@choa.org>) for additional assistance. | | | | | |