

Name:	
Title:	
Institution or Company:	
Department:	
Address:	
Email:	
Phone:	

Project Details

Title:	
Purpose: <i>Select all that apply.</i>	<input type="checkbox"/> Research <input type="checkbox"/> Education <input type="checkbox"/> Product development <input type="checkbox"/> Training <input type="checkbox"/> Validation <input type="checkbox"/> Other: _____ <input type="checkbox"/> Quality assessment
Describe the project including exactly how biospecimens will be used. <input type="checkbox"/> <i>Check if attaching a protocol.</i>	
Describe how the project design reflects the prevalence of the medical condition in the impacted patient population.	
Describe the project timeline including when biospecimens are needed.	
How long will samples be retained? Describe plans for residual biospecimens after the project is complete.	
What is the expected benefit back to Advocate Aurora Health (AAH)? <i>Select all that apply.</i>	<input type="checkbox"/> Acknowledgement in publications, posters, presentations, etc. <input type="checkbox"/> Authorship <input type="checkbox"/> Clinical trial(s) <input type="checkbox"/> Return of research data for AAH use (i.e. sequencing results) <input type="checkbox"/> Return of research specimens for AAH use (i.e. cell lines) <input type="checkbox"/> Summary of project results <input type="checkbox"/> Future collaborations <input type="checkbox"/> Other: _____

IRB	
Does the project have IRB approval?	<input type="checkbox"/> Yes <ul style="list-style-type: none"> • Name of IRB: _____ • IRB Number: _____ <input type="checkbox"/> No, Explain: _____ <input type="checkbox"/> Not needed – must provide documentation of non-HSR determination

Funding	
How is the project currently funded?	<input type="checkbox"/> Industry <input type="checkbox"/> Research Grant - Type: _____ <input type="checkbox"/> AAH Internal Funding - Cost Center: _____
Is funding available for biospecimen procurement activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the project is not currently funded, what are the plans to obtain funding? <input type="checkbox"/> Check if not applicable.	<input type="checkbox"/> Research Grant Submission <ul style="list-style-type: none"> • Type: _____ • Submission Date: _____ • Decision Date: _____ <input type="checkbox"/> Other: _____
If applying for a research grant, describe funding plans if not awarded. <input type="checkbox"/> Check if not applicable.	

Patient Cohort(s)			
Diagnosis(es): <i>Include ICD-10 codes if available.</i>		Primary organ tissue(s):	
Number of patients:			
Inclusion Criteria:		Exclusion Criteria:	

Biospecimen Details*Select all that apply.* **Whole Blood** Clinical remnant (EDTA K₂ only)

- # of aliquots: _____
- Volume per aliquot: _____

 Fresh

- Tube type: _____
- Number of tubes per patient: _____
- Total blood volume: _____
- Notes: _____
- Is sample aliquoting required?
 - No, please provide full collection tubes
 - Yes
 - # of aliquots: _____
 - Volume per aliquot: _____

 Plasma Clinical remnant (EDTA K₂ only)

- # of aliquots: _____
- Volume per aliquot: _____

 Fresh

- Tube type: _____
- Number of tubes per patient: _____
- Total blood volume: _____
- Notes: _____
- Is sample aliquoting required?
 - No, please provide full collection tubes
 - Yes
 - # of aliquots: _____
 - Volume per aliquot: _____

 Serum Clinical remnant (SST only)

- # of aliquots: _____
- Volume per aliquot: _____

 Fresh

- Tube type: _____
- Number of tubes per patient: _____
- Total blood volume: _____
- Notes: _____
- Is sample aliquoting required?
 - No, please provide full collection tubes
 - Yes
 - # of aliquots: _____
 - Volume per aliquot: _____

 Other (e.g., urine, saliva, buffy coat, etc.): _____ Clinical remnant

- # of aliquots: _____
- Volume per aliquot: _____

 Fresh

- Additional processing details: _____

 Tissue Fresh

- Tumor or diseased
 - Primary
 - Metastatic
- Normal or not diseased
- Minimum weight: _____
- Notes: _____

 FFPE

- Tissue block
- Tissue slides
 - Section thickness: _____ μm
 - Type of slides: _____
 - Notes: _____
- Number of slides: _____
- Number of sections per slide: _____
- Number of rolls in tube (no slide): _____

<p>Are unique patient samples required?</p> <p><input type="checkbox"/> Check if not applicable.</p>	<p><input type="checkbox"/> Yes, each sample (or set of samples) must be unique</p> <p><input type="checkbox"/> No, will accept duplicate samples from the same patient</p>
<p>If requesting sets of multiple biospecimen types from a patient, are partial sets acceptable?</p> <p><input type="checkbox"/> Check if not applicable.</p>	<p><input type="checkbox"/> Yes, will accept partial sets of biospecimens Explain: _____</p> <p><input type="checkbox"/> No, will only accept complete sets of biospecimens</p>

Data Annotation

Data Types *Select all that apply.* Check if attaching a separate list of data elements.

- | | | |
|--|---|--|
| <input type="checkbox"/> Age | <input type="checkbox"/> Pathology report (redacted) | <input type="checkbox"/> Treatment history |
| <input type="checkbox"/> Gender | <input type="checkbox"/> Biopsy report (redacted) | <input type="checkbox"/> Lab results |
| <input type="checkbox"/> Race / Ethnicity | <input type="checkbox"/> History & physical report (redacted) | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Height / Weight / BMI | <input type="checkbox"/> Tobacco / alcohol use | <input type="checkbox"/> Surgical history |
| <input type="checkbox"/> Other: _____ | | |

What level of data identification is needed?

Check if not applicable.

- | | |
|--|--|
| <input type="checkbox"/> De-identified data
This is the preferred option. Dates cannot be provided, but number of days between events can be shared. Please contact us for details. | <input type="checkbox"/> Identifiable data
This option is rarely allowed. |
|--|--|

How should the data be provided?

Check if not applicable.

- | | |
|--|---|
| <input type="checkbox"/> Excel spreadsheet
<input type="checkbox"/> Existing file (please attach copy)
<input type="checkbox"/> Need assistance to create | <input type="checkbox"/> Electronic data capture system
• Name: _____ |
| <input type="checkbox"/> Case report form
<input type="checkbox"/> Existing file (please attach copy)
<input type="checkbox"/> Need assistance to create | <input type="checkbox"/> Redacted reports only |

Additional Information:

Internal Use Only			
Date Received:		Date Reviewed by BUPRC:	
Decision:		Project Prioritization Score:	
BSRC IRB:	<input type="checkbox"/> No <input type="checkbox"/> Yes, IRB #: _____	Competing Studies:	<input type="checkbox"/> No <input type="checkbox"/> Yes