

**Digestive Health Foundation Biorepository:
Sample Collection and Storage Request Form**



Date of Submission:			
REQUESTER'S NAME AND CONTACT INFORMATION			
Name:			
Department/Division:			
Contact Information:	Email:		Telephone:
SUMMARY			
Services desired: <input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval of stored samples			
Sample type: <input type="checkbox"/> blood or derivatives (plasma, serum) <input type="checkbox"/> tissue samples			
If tissue, location of samples: <input type="checkbox"/> esophagus <input type="checkbox"/> intestine <input type="checkbox"/> other (specify: _____)			
Number of samples:			
Desired start date:			

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PROJECT DETAILS	
Project Title:	
PI Name:	
Project Description:	
Anticipated Date of Project Initiation:	
IRB #	
Funding Source(s):	Chart string #:

BIOLOGICAL SAMPLES REQUESTED

A) What type of SAMPLES would you like?

Example: If you need serum samples and the experiment requires 80-100 µl per sample, check the box for “Serum” below and enter “80-100 µl” under quantity.

Sample Type	Quantity (e.g. volume)	Other Specifications for Sample Condition and Tissue type	Service Desired
<input type="checkbox"/> Tissue stored in all Protect			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval
<input type="checkbox"/> Plasma			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval
<input type="checkbox"/> Formalin Fixed sample			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval
<input type="checkbox"/> Serum			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval
<input type="checkbox"/> Tissue stored in RNA later			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval
<input type="checkbox"/> Whole Blood- Paxgene Tube			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval
<input type="checkbox"/> Other (please specify)			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval
<input type="checkbox"/> Fresh Tissue (please specify solution to be stored in)			<input type="checkbox"/> sample collection only <input type="checkbox"/> sample collection and storage <input type="checkbox"/> retrieval

BIOLOGICAL SAMPLES REQUESTED (cont.)

B) From which type of PARTICIPANTS would you like samples?

Clinical Diagnosis	Number of Participants Requested	Inclusion/Exclusion Criteria

C) Please specify any MATCHING CRITERIA (e.g. age, sex, ...) between diagnosis groups:

D) Would you like samples from A SINGLE TIME POINT or MULTIPLE TIME POINTS per person?

- Single time point (i.e. cross-sectional samples)
- Multiple time points (i.e. longitudinal samples), specify:
 - a) # of time points per person: _____
 - b) Other specifications (e.g. only want longitudinal samples at least 6 months apart):

E) Additional specifications not covered above:

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CLINICAL DATA REQUESTED	
Specify Required Data/Variables:	

FOR INTERNAL USE ONLY

Request ID:	
Date request received:	
Requires review by DHF Biorepository Committee:	<input type="radio"/> No <input type="radio"/> Yes, date of review: _____
Decision:	<input type="radio"/> Approved <input type="radio"/> Denied, reason: _____
Date of approval/denial notification to requester:	
Notes or comments:	