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:

|  |  |
| --- | --- |
| **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 CAP [ ]  [ ]  |

|  |  |
| --- | --- |
| **Projected # of Subjects:** |       |
| **Main Contact / Study Coordinator:** |       |
| **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: | **[ ] Yes [ ]  No**Please contact Investigational Pharmacist IDSRX@choa.org and provide copy of protocol with this request form for review and budget   Signature: Pharmacy Approval: |
| 1. **Pediatric Research Center?**

Date Requested:PRU Approval: | **[ ] Yes [ ]  No**Please contact Cheryl Stone, PRU Team Lead (404.785.6454), and provide a copy of protocol with this request form for review and budgetFor complete instructions on how to process your proposal through CTSA Research Committee at Emory and Children’s contact Cheryl Stone      Signature:  |

|  |  |
| --- | --- |
| 1. **Cardiovascular Imaging Research Core?**

CIRC Approval: | **[ ] Yes [ ]  No**Please contact with Joan Lipinski, CIRC manager, and provide copy of protocol with this request form for review and budget      Signature: Date Requested: |

|  |  |  |
| --- | --- | --- |
| **ECG**? If yes, what type: | **[ ]** Yes | **[ ]** No |
| Put ECG in medical record/needs to be read? (will include pro fees) | **[ ]** Yes | **[ ]** No |
| **Echo?** If yes, what type? | **[ ]** Yes | **[ ]** No |
| Put echo in medical record/needs to be read? (will include pro fees) | **[ ]** Yes | **[ ]** No |
| Will study need echo discs de-identified ***and/or*** data uploaded to online portal? | **[ ]** Yes | **[ ]** No |
| Training required for staff? | **[ ]** Yes | **[ ]** No |
| If training required: | **[ ]** Coordinators**[ ]** Sonographers | Approximately how long (hours)?Approximately how long (hours)? |
| Additional comments/notes: |

|  |  |
| --- | --- |
| 1. **Pediatric Procedural Sedation Services?**

Provide detail of services needed:      Date Requested:Services Approval:        | **[ ] Yes [ ]  No****[ ]** Egleston – Contact: Dr. Pradip Kamat**[ ]** Scottish Rite – Contact: Dr. David Werner |

|  |  |
| --- | --- |
| 1. **Surgical Services (Anesthesia)**

Meet with the manager of each service line needed for costs and approval**.**Please contact with: Mary Heath – Mary.Heath@choa.orgTiffany Bayless Tiffany.Bayless@choa.org – CT Surgery and ENTStefany Hall – Stefany.Hall@choa.org - Orthopedics, Plastics, Pediatric Surgery (general), GYNEmily Jennings – Emily.Jennings@choa.org - Neurosurgery, Anesthesia |  **[ ] Yes [ ]  No**Reminder: Inquire if OR and PACU charges are needed. |

|  |  |
| --- | --- |
| 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**Outpatient Hours of Operation:****Egleston and Scottish Rite: Monday – Friday 8am-8pm** **CAP: Monday – Friday 8am – 5:30pm***\*\*Study Coordinator must accompany patient to patient registration and during time of draw for outpatient 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**.*

*For additional questions and inquiries, please contact:* *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 Manager, **Carlos Miller** | Microbiology/ Virology, **Jonelle McKey** |
| Core Lab(Egleston), **Maria Ana Atuan** | Core Lab(Scottish Rite), **Sandra Estelle** |
| Blood Bank Services, **Shannon Pahz** | Lab Research Coordinator, **Bethany Watson**  |
| System Laboratory Manager, **Julie Piccini** | Anatomical Pathology Director, **Dr. Hong Yin** |
| Lab Support Services Supervisor, **KiKi Williams** (Egleston) | Lab Support Services Supervisor, **Brigitte Thompson** (Scottish Rite) |
| Lab Services Manager, **Darlene Gomez** (CAP) | Outpatient Phlebotomy Team Lead, **Deonte Goggins** (CAP) |
| Business Operations Manager, **Teresa Leffew** (Egleston/Scottish Rite) | MTIII, **Susan Bayus** (CAP) |

|  |  |
| --- | --- |
| 1. **Rehabilitation Services?**

Rehab Approval: | **[ ] Yes [ ]  No**Please contact with Susannah Kidwell, Director of Rehabilitation Services, and provide copy of protocol with this request form for review and budget      Signature: Date Requested: |

|  |  |
| --- | --- |
| 1. **Radiology Services?**
 | **[ ] Yes [ ]  No** |
| **Is Sedation Required?** | **[ ] Yes [ ]  No** |
| **Is PACU- Recovery Required?** | **[ ] Yes [ ]  No** |

|  |  |
| --- | --- |
| Initiation Fee |  **[ ]** Waived   **[ ]** $750 one-time charge |
| Maintenance Fees |  Not Applicable  Waived  $50/month when services are used\_\_ patients \_\_ scans each = \_\_ possible months |
| Procedure Name | CPT | Egleston Technical Fee | Interpretation Fee | Scottish Rite Technical Fee | Scottish Rite Interpretation Fee |
|  |  |  |  |  |  |

List name and CPT code for each scan or procedures:

Date Requested:

Please contact Jack Goldberg, 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. **REDCap -** database needed.

Please contact: redcap@choa.org if CHOA database is required. | **[ ] Yes [ ]  No** |

|  |  |
| --- | --- |
| 1. **Other Departments?**

Meet with the manager of each service line needed for costs and approval |  **[ ] Yes [ ]  No** |