|  |
| --- |
| **Please refer to *Young Adult Access to Paediatric Cancer Clinical Trials Standard Operating Procedure* for further information.**  |
| **Patient details:** |
| Name: |  |
| Date of Birth (Age): |  |
| Diagnosis:  |  |
| Prognosis: |  |
| Current treating hospital:  |  |
| Current treating Clinician: | *Name:* |
| *Email:* |
| Proposed paediatric Clinician: | *Name:* |
| *Email:* |
| **Clinical Trial details:** |
| HREC Reference |  |
| Trial Name |  |
| Principal Investigator | *Name:* |
| *Email:* |
| Contact person | *Name:* |
| *Email:* |
| Does the patient meet all clinical trial eligibility requirements? Please provide detail and comments as needed e.g. pending final screening post consent. | Age: [ ]  YES [ ]  NO |
| Diagnosis: [ ]  YES [ ]  NO |
| Prior treatment: [ ]  YES [ ]  NO |
| Molecular screening: [ ]  YES [ ]  NO |
| Other, please state:  |
| Comments:  |
| If no to any of the above, has a protocol deviation been approved by the sponsor and HREC? | [ ]  YES [ ]  Not ApplicableComments:  |
| What is the primary reasoning for seeking access to the clinical trial? | [ ]  No other remaining treatment options[ ]  No relevant clinical trials available at adult centres[ ]  Potential for improved prognosis[ ]  Other, please state |
| Please provide detail on potential benefit to patient |  |
| **Resourcing Requirements:** |
| Proposed model of ongoing care | [ ]  Full transfer[ ]  Shared Care[ ]  ‘Secondment’[ ]  Other, please stateComments:  |
| Staffing required |  |
| Services required |  |
| Space required |  |
| Is in-patient stay required? If yes, provide details\* |  |
| Plan for post-trial transition back to adult care |  |
| Funding sources, please provide detail e.g. Sponsor, Medicare, Referring hospital, Receiving hospital |  |

|  |
| --- |
| **APPROVALS**  |
| **Director, Paediatric Cancer Centre** |
| Signature:  | Date:  |
| **Director, Research Ethics & Governance** |
| Signature:  | Date:  |
| **Chief Medical Officer**  |
| Signature:  | Date:  |
| **\*Chief Operating Officer (only where in-patient resources are required)**  |
| Signature:  | Date:  |