

<p><b>For Consulting Center Use Only:</b></p> <p><b>Date Received:</b> _____</p> <p><b>Assigned to:</b> _____</p> <p><b>Date Assigned:</b> _____</p> <p><b>Assigned by:</b> _____</p> <p><b>Completed date:</b> _____</p> <p><b>Reviewer Initials:</b> _____</p> <p><b>Supervisory Concurrence:</b> _____</p>
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## Intercenter Request for Consultative or Collaborative Review Form

**To (Consulting Center):**

Center:  
 Division:  
 Mail Code: HF  
 Consulting Reviewer Name:  
 Building/Room #:  
 Phone #:  
 Fax #:  
 Email Address:  
 RPM/CSO Name and Mail Code:

**From (Originating Center):**

Center:  
 Division:  
 Mail Code: HF  
 Requesting Reviewer Name:  
 Building/Room #:  
 Phone#:  
 Fax #:  
 Email Address:  
 RPM/CSO Name and Mail Code:  
 Requesting Reviewer's Concurring  
 Supervisor's Name:

**Receiving Division: If you have received this request in error, you must contact the request originator by phone immediately to alert the request originator to the error.**

Date of Request:

**Requested Completion Date:**

Submission/Application Number:  
 (Not Barcode Number)

Submission Type:  
 (510(k), PMA, NDA, BLA, IND, IDE, etc.)

Type of Product: .. Drug-device combination    .. Drug-biologic combination    .. Device-biologic combination  
 .. Drug-device-biologic combination    .. Not a combination product

Submission Receipt Date:

Official Submission Due Date:

Name of Product:

Name of Firm:

Intended Use:

Brief Description of Documents Being Provided (e.g., clinical data -- include submission dates if appropriate):

Documents to be returned to Requesting Reviewer?     Yes     No

**Complete description of the request.** Include history and specific issues, (e.g., risks, concerns), if any, and specific question(s) to be answered by the consulted reviewer. The consulted reviewer should contact the request originator if questions/concerns are not clear. Attach extra sheet(s) if necessary:

Type of Request:     Consultative Review     Collaborative Review