

**For Consulting Center Use Only:**

**Date Received:** \_\_\_\_\_

**Assigned to:** \_\_\_\_\_

**Date Assigned:** \_\_\_\_\_

**Assigned by:** \_\_\_\_\_

**Completed date:** \_\_\_\_\_

**Reviewer Initials:** \_\_\_\_\_

**Supervisory Concurrence:** \_\_\_\_\_

## 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