**Research Study Request for Services Summary Form**

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| Principal Investigator: Click here to enter text.  Medical Staff  Non-Medical Staff | |
| Study Name: Click here to enter text. | |
| REB #: Click here to enter text. Study Nickname: Click here to enter text. | |
| Name & Contact for Research (e.g. Research Coordinator): Click here to enter text.  Name & Contact for Invoicing, if different from above:Click here to enter text. | |
| Email: Click here to enter text. | Telephone or Pager: Click here to enter text. |
| Indicate the clinical area(s) where the study procedure(s) will be carried out:  SPH Pulmonary Diagnostics Lab 8D SPH Bronchoscopy Suite 8D  SPH Respiratory Education Centre 8B SPH Cardiology Lab 2B (Cardiopulmonary Exercise Test) | |
| *Summary of Research, point form (please do not exceed 250 words)*  *1. Purpose:*  Click here to enter text.  *2. Hypothesis:*  Click here to enter text.  *3. Justification:*  Click here to enter text. *4. Objectives:* Click here to enter text.  *5. Research Method:*  Click here to enter text. *6. Statistical Analysis:*  Click here to enter text. | |

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| --- | --- |
| *Preferred start date:*  Click here to enter text. | *Anticipated completion date:*  Click here to enter text. |
| *Number of expected participants:*  Click here to enter text. | |
| *Procedures/Services Requested:*  Click here to enter text. | |
| *Number of visits required*  Click here to enter text. | |

**IMPACT ON PHC STAFFING RESOURCES:**

1. Will study procedures be scheduled outside of normal operating hours (0800-1600 Monday-Friday)?

No  Yes If **YES,** please indicate the preferred days/times of the week and expected frequency: Click here to enter text.

1. Will PHC employees be required to collect any data and/or samples beyond what would normally be collected for routine clinical care? (I.e. calibration data, non-standard parameters, extra samples, etc.)

No  Yes If **YES**, please indicate the type of data and/or samples required and an estimation of the total amount of time required:

Click here to enter text.

1. Will PHC employees be required to enter data into study databases?

No  Yes If **YES,** please indicate estimated total amount of time required:

Click here to enter text.

1. Please list any other tasks required of PHC employees for this study:

Click here to enter text.

1. Does the research protocol require additional nursing care, respiratory therapy or other allied health services? Please indicate all that apply.

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| --- | --- | --- |
| **Type of Nursing Care, Respiratory Therapy or other Allied Health Services** | **Estimated Frequency**  **& Duration** | **N/A** |
| Vital signs monitoring (i.e. increased blood glucose monitoring); test preparation (specify) | Click here to enter text. |  |
| Specimen collection; administration of study medication | Click here to enter text. |  |
| Prolonged length of stay; admission | Click here to enter text. |  |
| Other unit/clinic resources impacted by the study | Click here to enter text. |  |

1. Outline how you will provide information to respiratory therapy, nursing or other unit staff about their role in the study. Consultation with the clinical area operational leader is recommended for more complex protocols.

Click here to enter text.

**IMPACT ON RESOURCES:**

*The program/department will determine if the required services necessitate recovery from the study budget to offset costs. The program/department leader will provide study investigators with the cost of services.*

1. Is the study funded?

No  Yes If **YES**, source of funds: Click here to enter text.

1. Will the study result in any additional costs to the program/department (i.e. equipment, supplies)

No  Yes If **YES**, are those costs covered by the study funds? Click here to enter text.

No  Yes If **NO**, please indicate who will cover the costs: Click here to enter text.

1. Will we need to purchase additional supplies?

No Yes If **YES**, please list required supplies:

Click here to enter text.

*If the time commitment or resources required is greater than initially anticipated, we reserve the right to review our continued involvement and the need for the study budget to provide resources to the program/department.*

**AGREEMENT**

Operational and clinical issues have been reviewed and resolved to my satisfaction. Therefore, the research study \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may proceed in the clinical area known as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, pending receipt of the Certificate of Ethical Approval **AND** the PHC Institutional Certificate of Final Approval. The study investigator will be responsible for providing the Professional Practice Leader with copies of both certificates of approval.

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*Approver (print name)* *Signature*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Title*  *Date*

**SERVICE RECOVERY COSTS:**

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| --- | --- | --- | --- |
| **Service/Test** | **Frequency** | **Cost per Test** |  |
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**Patient tracking Information will be sent monthly to the research coordinator indicated for verification. Invoices and funds are managed by HSSBC.**

**PFT Booking Information:**

Contact Pulmonary Diagnostics Coordinator to arrange for study appointments.

**Maria Li**,

Pulmonary Diagnostics Coordinator

604-682-2344  ext   62082

mli@providencehealth.bc.ca

The PF Lab requires a requisition (FORM PHC-RE001) for every patient that is tested. The form needs to contain the following information:

* 3 patient identifiers (Name, Birthday, PHN)
* Physician signature
* Diagnosis
* Test required (marked in the check boxes)
* Study name
* Test date

The patient/coordinator will bring the Req to PF Lab on day of testing to ensure the therapist can perform the right test on the right patient.

**Bronchoscopy Booking Information:**

Bookings are done per clinical procedure processes.

