

Protocol Title:		
Principal Investigator(s): If student is PI, please list advisor:		
Is this Study part of a Student Thesis Project?	<input type="checkbox"/> BSc Med/Dent <input type="checkbox"/> Masters <input type="checkbox"/> PhD	
Site Name:	File Number:	
Proposed Start Date:	Estimated Completion:	

## STANDARDIZED INSTITUTIONAL RESEARCH COMMITTEE SUBMISSION FORM

*Please include a copy of the REB application form with your submission and check with the relevant site for other submission requirements.*

- Type of Study:**     Adult     Pediatric     Both
- Please specify: a)     Clinical Research     Other (please specify) \_\_\_\_\_  
                           Health Services / Policy / Public Health Research
- b)     Primary Data Collection     Secondary Data Analysis     Both

1. Is this study funded?  Yes     No (If no, explain \_\_\_\_\_)
- a) If yes, please state source, amount and time frame \_\_\_\_\_
- b) If no, please include budget, and indicate how the costs of the Study are to be supported and the time frame \_\_\_\_\_

- 2a. Funds to be administered by (Finance department)
- Concordia     CCMB     Deer Lodge     HSC     MATC     Misericordia  
 Riverview     Rehab Ctr.     Seven Oaks     SBGH     Victoria     U of M\*  
 WRHA     Grace     Pan Am     Other     Not applicable

- 2b. Which facilities do you intend to work at:
- Concordia     CCMB     Deer Lodge     HSC     MATC     Misericordia  
 Riverview     Rehab Ctr.     Seven Oaks     SBGH     Victoria     U of M  
 WRHA     Grace     Pan Am  
 Public Health/WRHA Office/Access Centre – (Please Name) \_\_\_\_\_  
 Other: (Please Name) \_\_\_\_\_     Not applicable

*\*According to the Master Affiliation Agreement between WRHA and U of M, if the Researcher has any affiliation with U of M, funds from the Tri-Council should be handled through U of M.*

3. Will the approved site(s) be identified in publications?  Yes     No
- a) If no, please provide rationale for your answer: \_\_\_\_\_

4. Is Space required to conduct this study?  
 Yes (explain where and what kind) \_\_\_\_\_  
Has Space been negotiated/assigned? \_\_\_\_\_  
 No
5. Have all study personnel signed the PHIA Pledge of Confidentiality Yes  No  (if no, it is the Principal Investigator's responsibility to ensure the pledge is signed).
6. How does this research lead to information that will support the organization's Mission and Strategic goals? \_\_\_\_\_
7. Are any WRHA resources required including employee participation, equipment, or money?  
 Yes  No
- a) If yes, please specify and indicate how much, how many and for what period of time: \_\_\_\_\_
- It is incumbent upon the researcher to negotiate the dedication of resources to this project prior to submission. Please include a written statement of support from the Managers directly in control of all the resources required, or a higher level of managerial responsibility. In cases where a manager is also a co-investigator, the level of support must come from at least one level above that individual.*
8. How will access to research/subjects be achieved?  
\_\_\_\_\_
9. Who are the institutional contact(s) for this study?  
\_\_\_\_\_
10. Will any of the following areas be involved? Yes  No

**a) Check off all affected areas that apply:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Biomedical Engineering  | <input type="checkbox"/> Central Processing     | <input type="checkbox"/> Com. Disorders       |
| <input type="checkbox"/> Dietetics               | <input type="checkbox"/> E-Health               | <input type="checkbox"/> Energy Management    |
| <input type="checkbox"/> Home care general       | <input type="checkbox"/> Housekeeping           | <input type="checkbox"/> Infusion pumps       |
| <input type="checkbox"/> MB Home Nutrition       | <input type="checkbox"/> Medical records        | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Patient Registration    | <input type="checkbox"/> Patient Records        | <input type="checkbox"/> Patient Relations    |
| <input type="checkbox"/> Pediatrics              | <input type="checkbox"/> Physical Plant         | <input type="checkbox"/> Physiotherapy        |
| <input type="checkbox"/> Plant Maintenance       | <input type="checkbox"/> Printing               | <input type="checkbox"/> Protection Services  |
| <input type="checkbox"/> Purchasing              | <input type="checkbox"/> Social Work            | <input type="checkbox"/> Spiritual Care       |
| <input type="checkbox"/> Supply and Distribution | <input type="checkbox"/> Therapeutic Recreation | <input type="checkbox"/> Other: _____         |

If the study is to be done at more than one facility/site, please specify which of the above resources are needed and specify at which proposed sites/facilities.

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

11. Will **Pharmacy Services** be required? Yes  No  (if no, please go to #12)

a) Who will administer the study drug?

Research Nurse  Unit Nurse(s)  Patient/LAR: \_\_\_\_\_

Which Site (s) \_\_\_\_\_

12. Will Hospital **Nursing** resources be required? Yes  No  (if no, please go to #13)

a) **If yes, which unit(s):** \_\_\_\_\_

b) **If yes, please check off required activity(s):**

Activity	Freq	Research Nurse	Staff Nurse	Activity	Freq	Research Nurse	Staff Nurse
Vital Signs	_____	<input type="checkbox"/>	<input type="checkbox"/>	Establishing of IV	_____	<input type="checkbox"/>	<input type="checkbox"/>
Infusion of Meds	_____	<input type="checkbox"/>	<input type="checkbox"/>	Temperature	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rate	_____	<input type="checkbox"/>	<input type="checkbox"/>	Specimen Collection	_____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Observation	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Monitoring	_____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Respirations	_____	<input type="checkbox"/>	<input type="checkbox"/>
IV Therapy	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ambulations	_____	<input type="checkbox"/>	<input type="checkbox"/>
Fluid Intake/Output	_____	<input type="checkbox"/>	<input type="checkbox"/>	Documentation	_____	<input type="checkbox"/>	<input type="checkbox"/>

c) Other Activities: \_\_\_\_\_

d) Increased Nurse: Patient Ratio: \_\_\_\_\_ (1:1, 2:1, 4:1, 6:1, Other)

e) Additional supplies needed: \_\_\_\_\_

f) Is inpatient stay required or extended: \_\_\_\_\_

13. Will **Ambulatory Care Clinic Services** be required? Yes  No  (if no, go to #14)

a) **If yes, which unit (s) or clinic (s)?** \_\_\_\_\_

b) Will any of the visits be over and above usual patient care? Yes  No

c) **If yes, will services of the Ambulatory Care Nurse / Clerk / Assistant be required?**

Yes  No

Which Site (s): \_\_\_\_\_

**If yes, please specify:**

\*\*\* PLEASE USE THIS FORM. THIS IS A PILOT TEST OF A NEW FORM WHICH WILL BE REVISED RE YOUR COMMENTS AS YOUR FEEDBACK AND COMMENTS OF THIS FORM ARE APPRECIATED. THANK YOU. \*\*\*

I) Clerk:	Check	Freq	II) RN:	Check	Freq
Receiving & Registering	<input type="checkbox"/>	_____	Assessment	<input type="checkbox"/>	_____
Appointment Scheduling	<input type="checkbox"/>	_____	Patient Education	<input type="checkbox"/>	_____
Medical Record Management	<input type="checkbox"/>	_____	Patient Enrolment	<input type="checkbox"/>	_____

d) Other Activities: \_\_\_\_\_

e) Are additional supplies needed (explain): \_\_\_\_\_

14. Will **Laboratory Services** be required? Yes  No

a) If yes, please specify which sites: \_\_\_\_\_

15. Will **Diagnostic Services** be required? Yes  No

Which Site(s) \_\_\_\_\_

a) If yes, please check off required service(s):

Radiology	Check	Cardiology	Check
C.T. Scanner	<input type="checkbox"/>	Echocardiography / Trans-esophageal echo	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	Holter Monitoring	<input type="checkbox"/>
Angiography	<input type="checkbox"/>	EKG	<input type="checkbox"/>
Radiography	<input type="checkbox"/>	Stress Test	<input type="checkbox"/>
MRI	<input type="checkbox"/>	Coronary Angiography	<input type="checkbox"/>
Neurology	Check	Cardiac Cath Lab	<input type="checkbox"/>
EEG	<input type="checkbox"/>	Sleep Lab	<input type="checkbox"/>
EMG	<input type="checkbox"/>	Are you involved in Pharmacogenetics?	<input type="checkbox"/>
Evoked Potentials	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>

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**Signature and Date**

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**Advisor (if PI is student)**

Please send this Research Submission Form with <u>original</u> signatures and ten (7) of copies of each documentation specific to the Institution to which you are applying.
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