APPENDIX B – OTTAWA HEALTH SCIENCE NETWORK RESEARCH ETHICS BOARD APPLICATION FORM

**REQUEST FOR UOHI DIAGNOSTIC SERVICES FOR A PROPOSED RESEARCH PROTOCOL**

***Please forward all required information, including the study protocol to the appropriate Manager/Director, prior to submission to the REB and uploading into the CRRF.***

***Use the “TAB” key to move between fields:***

1. Title of Protocol:



Acronym to be used for EPIC Smart text:

1. Principal Investigator (at this site):



Room #:       Telephone #: (   )    -     Ext.:





Contact Person:       Telephone #: (   )    -     Ext.:





1. Duration of Project (in months):

Anticipated Start Date:       Month:       Year:





1. a) Number of Inpatients:



b) Location (Service and Ward(s)):



1. Number of Outpatients:



1. a) Cost Centre or OHIRC Account for Billing Purposes:



b) Invoice Investigator (indicate where invoice to be sent):



c) Industry sponsored or funded study:



1. Will copies of images be sent to an external sponsor/core lab/coordinating centre:

If ‘yes’, impact approval and costing is required from the Cardiac Imaging Research Core Lab (CIRCL); use mandatory to ensure adequate de-identification of records prior to release.

**Use table on next page to provide details of requirements and obtain costing.**



Echocardiogram, Electrocardiogram, Stress Test, CT, PET, Nuclear, MRI and/or General X-Ray:

**APPROVED by the Director Cardiac Imaging: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Cardiac Catheterization:

**APPROVED by Medical Director, Cardiac Cath Lab: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CIRCL:

**APPROVED by the Director CIRCL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**





|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Test(s)/Description of Services | Additional tech time required\*Y/N | **Contrast Required Y/N** | **Report Required Y/N** | # ofPatients | # of Testsper Patient | Total Tests | | Cost Per Patient | | Total Cost |
| **Clinical** | **Research**  (Not routine or standard of care) | **Prof.**  **Fee** | **Tech.**  **Fee** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

\*Additional tech time, in minutes, required per scan to complete additional images/views, etc., to be included in Epic smart text protocol.

**Please note:** a $50.00 fee will be charged to the research team if the patient does not show for the scheduled appointment.

|  |
| --- |
| Notes/Comments regarding study |
|  |