 **Clinical Research Unit**

**Request for Services**

**\*Please include a copy of the Study Protocol (if applicable)**

|  |  |
| --- | --- |
| **FULL NAME**  | **FACULTY/DEPT/SCHOOL/PROGRAM** |
| **POSITION** |  **P.I. AFFILIATIONS**  **⁭ IWK ⁭ CDHA ⁭ DAL ⁭ Other** |
| **Phone EMAIL** |
| **PROJECT TITLE**  |
| **PROJECTED TIMELINES FOR REQUEST** |
| **Visit Type****(inpt/outpt)** | **Number of rooms** | **Start date** | **End date** | **Duration (if start/end dates unknown)** |
|  |  |  |  |  |
|  |  |  |  |  |
| **SERVICES REQUIRED** |
| **□FACILITY** |
|  ⁭ **Food services** |
| **□CLINICAL STAFF (provide details)** |
|  **⁭On-call services (specify)** |
| **□DIAGNOSTIC** |
|  **□Diagnostic imaging (specify)** |
|  **□Lab** |
|  **□Pharmacy** |
|  **□Cardiology (e.g., EKG)** |
|  **□Other (specify)** |
| **□PREPARATION OF ETHICS SUBMISSION** |
| **□RECRUITMENT** |
| **⁭RECORDS MANAGEMENT** **⁭ Case report form development** **⁭ Electronic data entry** **⁭ Other** |
| **□DATA MANAGEMENT/STATISTICAL. ANALYSIS** |
|  **⁭Other** |
| **ADDITIONAL COMMENTS****Please return the completed form to Cathy Brown, Clinical Coordinator at** **Catherine.brown@iwk.nshealth.ca** **or fax to: 902-470-7232** |
| **FOR OFFICE USE ONLY** |
| **DATE RECEIVED: STUDY CODE ASSIGNED:**  |
| **□ Approved** | **Date:** | **Sign:** |
| **□ Not approved Date: Sign:** **Reason:**  |