 **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**](mailto: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:** | | | | | | | |