Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | À l'écoute de notre santé

Judy Dyrland (Research Review Committee)
Concordia Hip & Knee Institute
200 – 1155 Concordia Avenue
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TEL: 204| 926.7034
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www.wrha.mb.ca

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Protocol Title:		
Principal Investigator(s) (Please include e-mail address, phone #, fax #):		
If student is PI, please list advisor:		
Is this Study part of a Student Thesis Project?	☐ BSc Med/Dent ☐ Masters ☐ 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

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**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 organizations' Missions and Strategic goals?_____

7. Are any WRHA or affiliated facility 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:

☐ Biomedical Engineering	☐ Central Processing	☐ Com. Disorders
☐ Dietetics	☐ E-Health	☐ Energy Management
☐ Home care general	☐ Housekeeping	☐ Infusion pumps
☐ MB Home Nutrition	☐ Medical records	☐ Occupational Therapy
☐ Patient Registration	☐ Patient Records	☐ Patient Relations

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☐ Pediatrics	☐ Physical Plant	☐ Physiotherapy
☐ Plant Maintenance	☐ Printing	☐ Protection Services
☐ Purchasing	☐ Social Work	☐ Spiritual Care
☐ Supply and Distribution	☐ Therapeutic Recreation	☐ Other: _____

If the study is to be done at more then 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	_____	☐	☐	Establishing of IV	_____	☐	☐
Infusion of Meds	_____	☐	☐	Temperature	_____	☐	☐
Heart Rate	_____	☐	☐	Specimen Collection	_____	☐	☐
Frequent Observation	_____	☐	☐	Cardiac Monitoring	_____	☐	☐
Blood Pressure	_____	☐	☐	Respirations	_____	☐	☐
IV Therapy	_____	☐	☐	Ambulations	_____	☐	☐
Fluid Intake/Output	_____	☐	☐	Documentation	_____	☐	☐

c) Other Activities: _____

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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:

I) Clerk:	Check	Freq	II) RN:	Check	Freq
Receiving & Registering	☐	_____	Assessment	☐	_____
Appointment Scheduling	☐	_____	Patient Education	☐	_____
Medical Record Management	☐	_____	Patient Enrolment	☐	_____

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	☐	Echocardiography / Trans-esophageal echo	☐
Ultrasound	☐	Holter Monitoring	☐
Angiography	☐	EKG	☐

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Radiography	☐	Stress Test	☐
MRI	☐	Coronary Angiography	☐
Neurology	**Check**	Cardiac Cath Lab	☐
EEG	☐	Sleep Lab	☐
EMG	☐	Are you involved in Pharmaco Genetics?	☐
Evoked Potentials	☐	Other: _____	☐

Signature and Date

Advisor (if PI is student)

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