GENERAL INFORMATION:

# Protocol Title:

# Short Study Title:

**Principal Investigator:**

**Coordinator:**

**Study Department:**  **Inpatient**  **Outpatient**  **ED**  **Radiology  Respiratory**

**Laboratory**

**Will you require Space for this study?  Research Visit Space  Storage of supplies/binders**

**Work Space for Non-Children's Employee  Specimen Storage Space**

**Study Sponsor or Funding Source:**

# of Visits

Number of Patients to be enrolled:

Are physician orders required for research drugs, procedures or tests?  Yes  No

Please contact Jermaine Dozier at 404-785-4592

DEPARTMENTS REQUIRED FOR RESEARCH PROCEDURES:

I. PHARMACY SERVICES NEEDED?  YES – SEE BELOW  NO – SKIP TO SECTION II

Does Study involve Investigational Drug? – Contact Jane Chen, Investigational Pharmacist (404-785-0342)

Approved by: Date:

Jane Chen, Research Pharmacist

1. VENIPUNCTURE or BLOOD DRAW SERVICES NEEDED?

YES – COMPLETE BELOW  NO – SKIP TO SECTION III

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Area(Primary Care/Specialty/ED)** | **Tests Requested** | **# of Tests Per Patient** |
|  |  |  |  |
|  |  |  |  |

To add rows: place cursor in far right box and press tab

Approved by: Date:

Nurse Manager

III. LABORATORY SERVICES?  YES – COMPLETE BELOW  NO – SKIP TO SECTION IV

THE TEST LISTED BELOW ARE THE ONLY INHOUSE LAB TEST PROVIDED

|  |  |  |
| --- | --- | --- |
|  | **Tests Requested** | **# of Tests Per Patient** |
| Pregnancy Urine |  |  |
| Urinalysis W/ Dip Stick |  |  |
| Rapid Strep |  |  |
| Hemoglobin |  |  |
| Hemoglobin A1-C |  |  |

To add rows: place cursor in far right box and press tab

Approved by: Date:

Angela Mosley, Lab Operations Supervisor

**IV. RESEARCH PROCESSING LABORATORY (SPECIMEN PROCESSING ONLY**) **(PLEASE NOTE THAT COURIER ARRANGEMENTS ARE NECESSARY)**

YES – COMPLETE BELOW  NO – SKIP TO SECTION V

**SUBMIT PROTOCOL TO labreasearchcoordinator@choa.org**

Processing  Storage Number of Specimens Per Patient

Processing Instructions:

Price quoted by Lab           (form must include price before approval by CHOA Research Department)

Approved by: Date:

**V. NON-INVASIVE CARDIOLOGY NEEDED?**  YES – COMPLETE BELOW  NO – SKIP TO SECTION VI **(THESE SERVICES ARE INPATIENT ONLY)**

|  |  |  |
| --- | --- | --- |
|  | **Type of Procedure** | **Number of Procedures Per Patient** |
| ECHO ONLY FOR INPATIENT |  |  |
|  |  |  |

Approved by: Date:

Angela McKeever, Manager of Respiratory Care

**VI. RESPIRATORY SERVICES NEEDED?**  YES – COMPLETE BELOW  NO – SKIP TO SECTION VII

|  |  |  |
| --- | --- | --- |
|  | **Type of Procedure** | **Number of Procedures Per Patient** |
|  |  |  |
|  |  |  |

Approved by: Date:

Angela McKeever, Manager of Respiratory Care

**VII. RADIOLOGY SERVICES NEEDED?**  YES – COMPLETE BELOW SECTION  NO

**THE SERVICES LISTED ARE THE ONLY RADIOLOGY SERVICES PROVIDED AT HUGHES SPALDING. ALL OTHER SERVICES PERFORMED AT GRADY**

|  |  |  |
| --- | --- | --- |
|  | **Type of Procedure** | **Number of Procedures per Patient** |
| Ultrasound |  |  |
| Fluoroscopy |  |  |
| Upper GI |  |  |
| Routine Diagnostics (Chest, Hand, Arm, etc.) Scans |  |  |

Approved by: Date:

Starla Jones, Manager of Radiology

**VIII. ED Used for Recruitment:**  YES – Get Signature  NO

Approved by: Date:

Dazzeney Williams, ED Nurse Manager

**IX. Clinic area Used for Recruitment:**  YES – Get Signature  NO

Approved by: Date:

Joron Murry, Practice Manager

**X. Inpatient Used for Recruitment:**  YES – Get Signature  NO

Approved by: Date:

Shari Baker, Manager Inpatient Unit

**STUDY EQUIPMENT/SUPPLIES**

The sponsor will be providing any patient supplies, equipment, or devices for this study to be used inside Children’s.

Please describe.

The study require Children’s purchasing any patient supplies, equipment, or devices.

If supplies or equipment are needed whether supplied by the sponsor or being purchased a Research –Only Requisition must be completed.

PLEASE REFER TO “PURCHASE ORDERS RESEARCH ONLY” TAB ON THE CLINICAL RESEARCH DEPARTMENT WEBSITE

Any equipment purchased must be inspected by clinical engineering and a copy of their approval letter sent to OSP.

Approved by: Date:

Gary Noland, System Manager, Clinical Engineering

**IMPORTANT NOTE:**

**PROFESSIONAL FEES FOR READING/INTERPRETING:**

**Please contact the Office of Sponsored Programs for specific assistance.**

* Radiology Fees- All Radiology performed at Hughes Spalding will be sent to Emory for reading. Please contact Emory for professional fee billing.
* Cardiology Fees- Sibley Heart Center will bill professional fee directly.
* For further assistance, please contact OSP at[**osp@choa.org**](mailto:osp@choa.org)

**Yvette Dean Date OR Yasmin Tyler-Hill Date**

**Director Patient Care Services Campus Medical Director**

**Children’s Healthcare of Atlanta Children’s Healthcare of Atlanta**

**Date**

**Financial Operations**

**Children’s Healthcare of Atlanta Hughes Spalding**

**OR**

**Shanta Laurie Date Kristine Rogers Date**

**Office of Sponsored Research Director of Research**

**Children’s Healthcare of Atlanta Children’s Healthcare of Atlanta**

**\_\_\_\_\_\_**

**Principal Investigator Date**