**ADULT & PEDIATRIC INFUSION CENTER**

**RESEARCH BUDGET ESTIMATE REQUEST FORM**

**Email completed form to:** adultinfusioncenterresearch@ucsf.edu

**\*Please complete ALL Required Fields marked with \***

|  |
| --- |
| **\*Protocol Title:** |
| **\*request type (check all that apply)**

|  |
| --- |
| [ ]  New Request [ ]  Update to Study Protocol/New Amendment [ ]  Other  |

 |
| **\*Principal Investigator:**  | Title(Professor, Associate Professor, etc.):        |
| Department**:**       | **Email:**  | Phone**:**       |
| **\*Financial Contact Name :**       | **\*Financial Contact Email :**  |
| Other Study Personnel Name(s) :       | Other Study Personnel Email(s) :        |

**\*Content Checklist FOR INFUSION CENTER REQUESTS**

**Please provide the following documents with your submission**

[ ]  Protocol

[ ]  Coverage Analysis Determinations\* (for nursing service requests at UCSF Medical Centers)

***\*Please note that a budget estimate requesting nursing services cannot be created without a record of the coverage analysis determination***

**\*Funding Information**

[ ]  **Funded** [ ]  **Pending funding**

|  |  |
| --- | --- |
| **\*Anticipated Start Date**: Click or tap to enter a date. | **\*Anticipated End Date**:Click or tap to enter a date.  |

**\*Funding Source**

*Please check the appropriate box and* ***specify the agency/sponsor name***

|  |  |  |  |
| --- | --- | --- | --- |
|[ ]  Federal (NIH, NSF, DOD, etc.)  |        |[ ]  Cooperative Group  |       |
|[ ]  Non-profit Organization |       |[ ]  Industry  |       |
|[ ]  Investigator Initiated (Industry) |       |[ ]  Investigator Initiated(non-industry) |       |

**Sites Requested**

|  |
| --- |
| **\*Adult & Pediatric Infusion Center Sites** |
|  [ ]  Mission Bay Adult (Monday-Friday, 8 – 8pm)  | [ ] Parnassus Adult (Monday-Friday, 8-7pm) |
|  [ ]  Mission Bay Pediatric  |  |

**\*PARTICIPANT POPULATION**

 [ ]  **Neonatal** [ ]  **Pediatrics** [ ]  **Adults** [ ]  **Geriatrics**

Birth – 2 years 2-17 years 18-64 years >64 years

**PROJECTED PARTICIPANTS at UCSF**

|  |  |  |
| --- | --- | --- |
| **\*Study Arm**(e.g. Screening, Arm A, etc.) | **\*# Participants** | **# Visits** |
|  |       |  |
|  |       |  |
|  |       |  |

 Please list only arms or cohorts that require **research** support from the infusion center or indicate ALL

[**NURSING**](http://ctsi.ucsf.edu/crc/services_matrix.php#nursing)

***Please select only the RESEARCH services you are requesting from the Infusion Center staff***

|  |
| --- |
| **Select RN services [use** [**Applicant Comments**](#applicantcomments) **section or** [**Special Requests**](#specialrequests) **box]** |
| [ ]  | Vitals Signs: Single position | [ ]  | Vital Signs : Multiple positions, Orthostatic |
| [ ]  |  Direct Venipuncture 4 tubes or less | [ ]  | Direct Venipuncture 5 tubes or more |
| [ ]  | Medication Administration: Standard***Do not check if billed to insurance*** | [ ]  | Medication Administration: IV***Do not check if billed to insurance*** |
| [ ]  | ECG (12 lead): Single time-point, No interpretation | [ ]  | ECG (12 Lead): Multiple time-points, No interpretation |
| [ ]  | PK Serial Blood Testing: # of time points =       | [ ]  | Facility Use for study team assessments, if needed (min) =  |
| **PROCEDURAL ASSISTANCE** |
| [ ]  | Moderate Sedation Administration by RN | [ ]  | Liver Biopsy Assistance |
| [ ]  | Bone Biopsy Assistance | [ ]  | Lumbar Puncture Assistance |
| **PATIENT MONITORING** |
| [ ]  | Observation [per hour] |
| **OTHER** |
| [ ]  | Blood / Blood Product Infusion | [ ]  | Blood Bag Draw up to 500cc |
| [ ]  | Apheresis/Leukapheresis | [ ]  | Hydration Pre and Post infusion |

|  |
| --- |
| **Applicant Comments:** |

**special budgetary requests**

|  |
| --- |
| Enter special requests or additional information here:      |