**ADULT & PEDIATRIC INFUSION CENTER**

**RESEARCH BUDGET ESTIMATE REQUEST FORM**

**Email completed form to:** [adultinfusioncenterresearch@ucsf.edu](mailto: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: |