**Please, RETURN THE COMPLETED FORM TO:**

Nicole Zytaruk via fax (905) 308-7223 or email zytaruk@mcmaster.ca

Thank you for your time and effort in completing this questionnaire.

|  |
| --- |
| Section 1. Investigator Contact Details |
| **Lead Investigator Name:** |
| **Email:** |
| **Hospital Name:** | **Affiliated University:**  |
| **Department:** | **Profession (i.e. MD, RN, etc..):** |
| **Mailing Address:** |
| **Contact Number:** | **Fax Number:** |
| **Co-Lead Investigator Name (s):** |

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| Section 2. Research Coordinator Contact Details (if applicable) |
| **Research Coordinator Name:** |
| **Email:** |
| **Department:** |
| **Mailing Address:** |
| **Contact Number:** | **Fax Number:** |

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| Section 3. Contract Officer Details (if applicable) |
| **Contract Officer Name:** |
| **Email:** |
| **Mailing Address:** |
| **Contact Number:** | **Fax Number:** |

**Demographics**

1. ICU demographics (check all that apply): [ ]  Adult [ ]  Paediatric [ ]  Neonatal
2. ICU population (check all that apply): [ ]  Medical/Surgical [ ]  Trauma [ ]  Neurologic [ ]  Cardiovascular
3. ICU structure: [ ]  Open unit [ ]  Closed unit
4. Number of ICU Units:
5. Number of ICU beds per Unit?
6. Number of patients admitted to the ICU annually per Unit?:

**Research Experience and Infrastructure**

1. Does the lead (co-lead) investigator have any previous research experience? [ ]  Yes [ ]  No
	1. If **yes**, how many observational studies? 0-4 [ ]  5-10 [ ]  >10 [ ]
	2. If **yes**, how many RCTs? 0-4 [ ]  5-10 [ ]  >10 [ ]
2. Do you have (a) Research Coordinator (s)? [ ]  Yes [ ]  No
	1. If **yes**, how many FTEs are working in research in your Unit?
	2. If **yes**, do you have off hours and weekend coverage? [ ]  Yes [ ]  No
3. Research Coordinator(s) Background: [ ]  Nurse [ ]  Respiratory Therapist [ ]  Other, specify:
4. Do the investigator and/or the research coordinator have Good Clinical Practice Guidelines certification?

Investigator [ ]  Yes [ ]  No Research coordinator [ ]  Yes [ ]  No

1. How often does your REB meet? [ ]  Weekly [ ]  Bi-weekly [ ]  Monthly [ ]  Other, specify:
2. Does your REB permit the following consent models?

Telephone consent?[ ]  Yes [ ]  No

Deferred consent? [ ]  Yes [ ]  No

Waived consent? [ ]  Yes [ ]  No

Fax consent? [ ]  Yes [ ]  No

1. Does your site co-enroll eligible patients (if approved by the steering committees)? [ ]  Yes [ ]  No
	1. If **no**, please specify reason:

1. Does your Pharmacy have resources to support research activities (e.g. randomization, mixing study product, study product accountability)? [ ]  Yes [ ]  No
	1. If **yes**, do they provide off hours/weekend coverage for enrollment and drug preparation? [ ]  Yes [ ]  No

1. The medical charts at your site are: [ ]  paper [ ]  electronic [ ]  hybrid (scanned)

 Comments:

1. Does your site have experience with Electronic Data Systems for data entry? [ ]  Yes [ ]  No

 **Academic Industry**

1. Does your site have start up fees for the following?

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$

 REB application [ ]  Yes [ ]  No If yes, how much?

$

$

 Laboratory protocol review and set up [ ]  Yes [ ]  No If yes, how much?

 Pharmacy protocol review and set up [ ]  Yes [ ]  No If yes, how much?

$

$

**Lead (Co-Lead) Investigator**

1. Will the lead (co-lead) investigator be accessible for oversight of study participants? [ ]  Yes [ ]  No
2. Will the lead (co-lead) investigator be accessible for procurement of regulatory and essential document signatures? [ ]  Yes [ ]  No

Thank you for your responses!

Comments?