**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):** | |

|  |  |
| --- | --- |
| 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

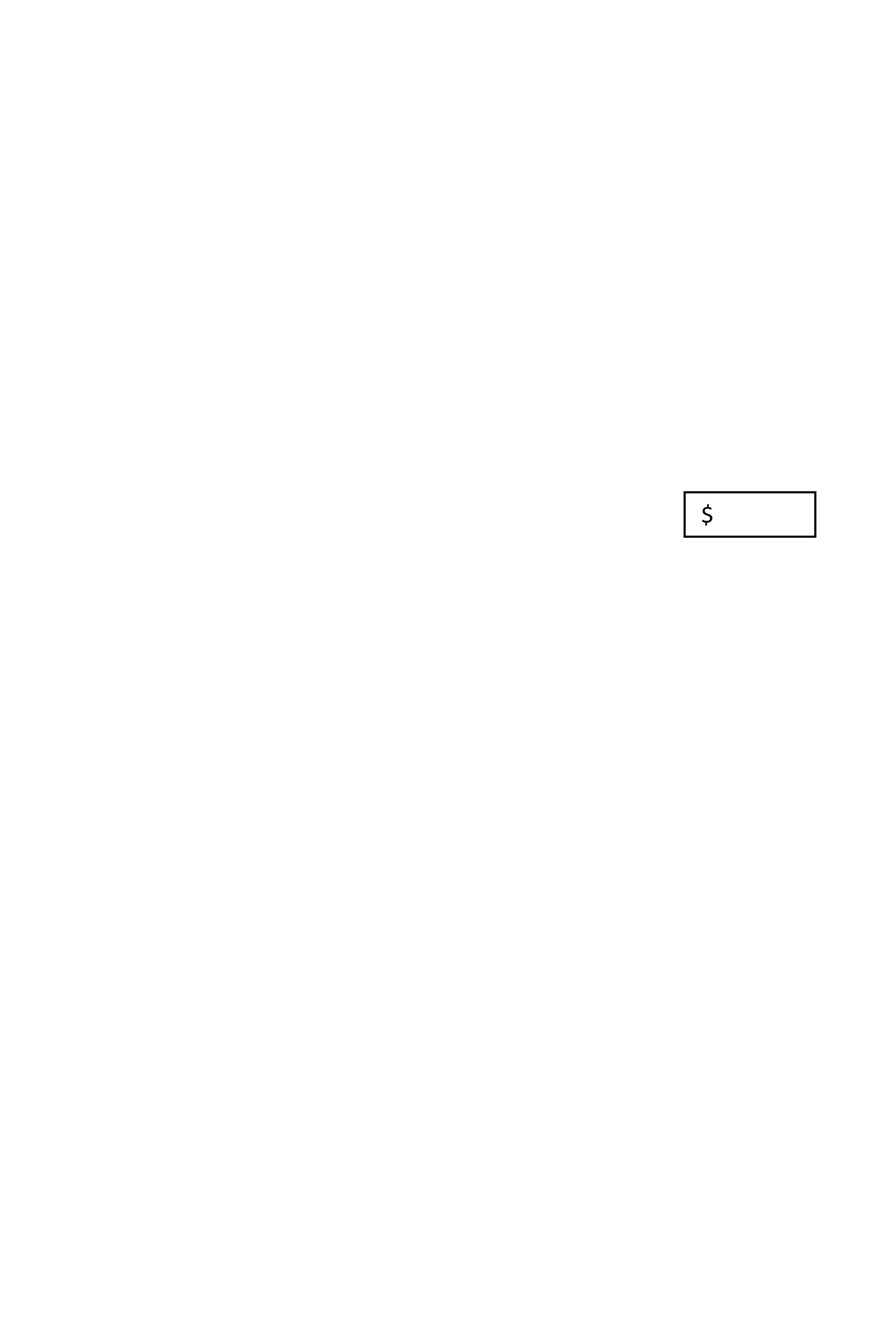
1. The medical charts at your site are:  paper  electronic  hybrid (scanned)

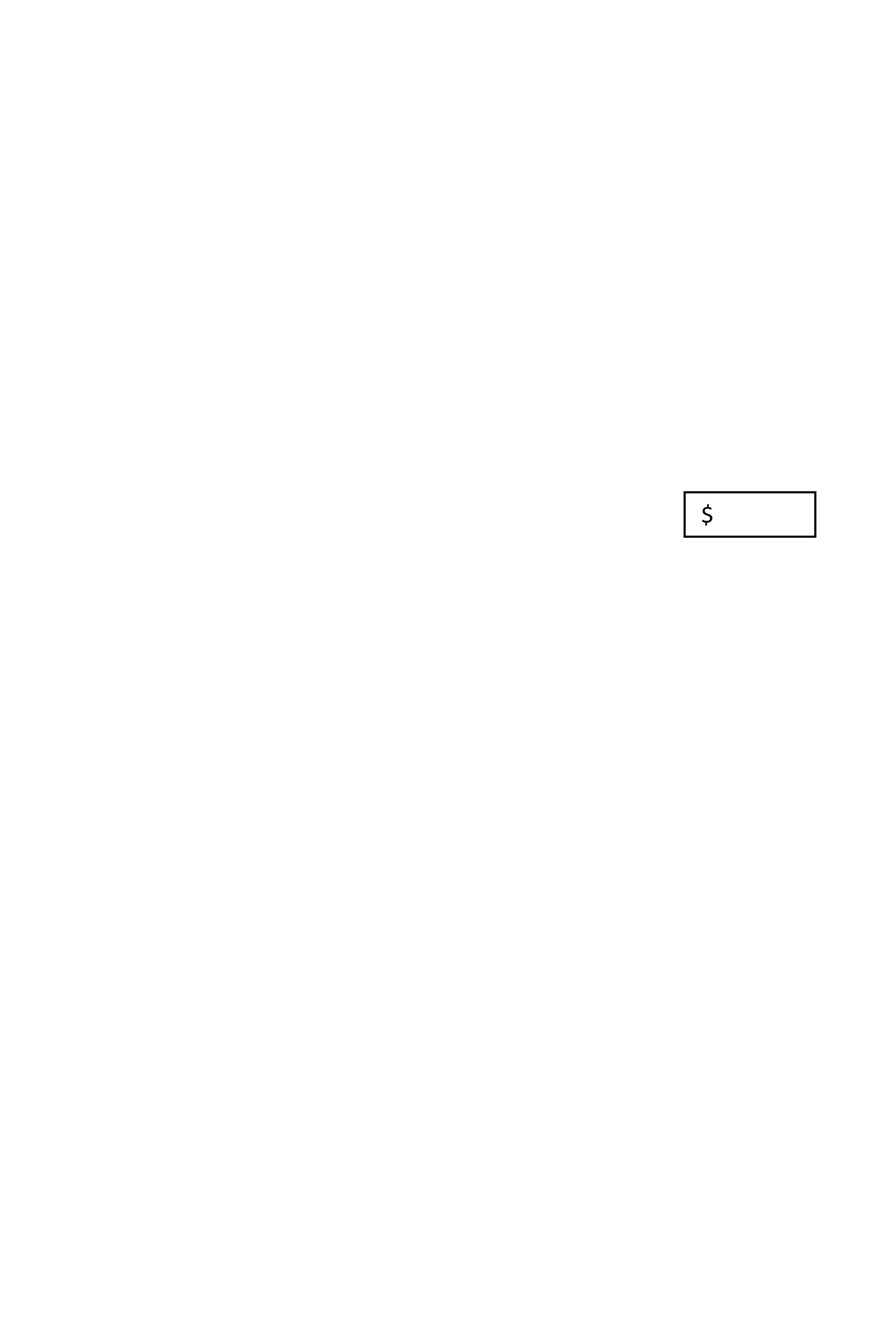
Comments:

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

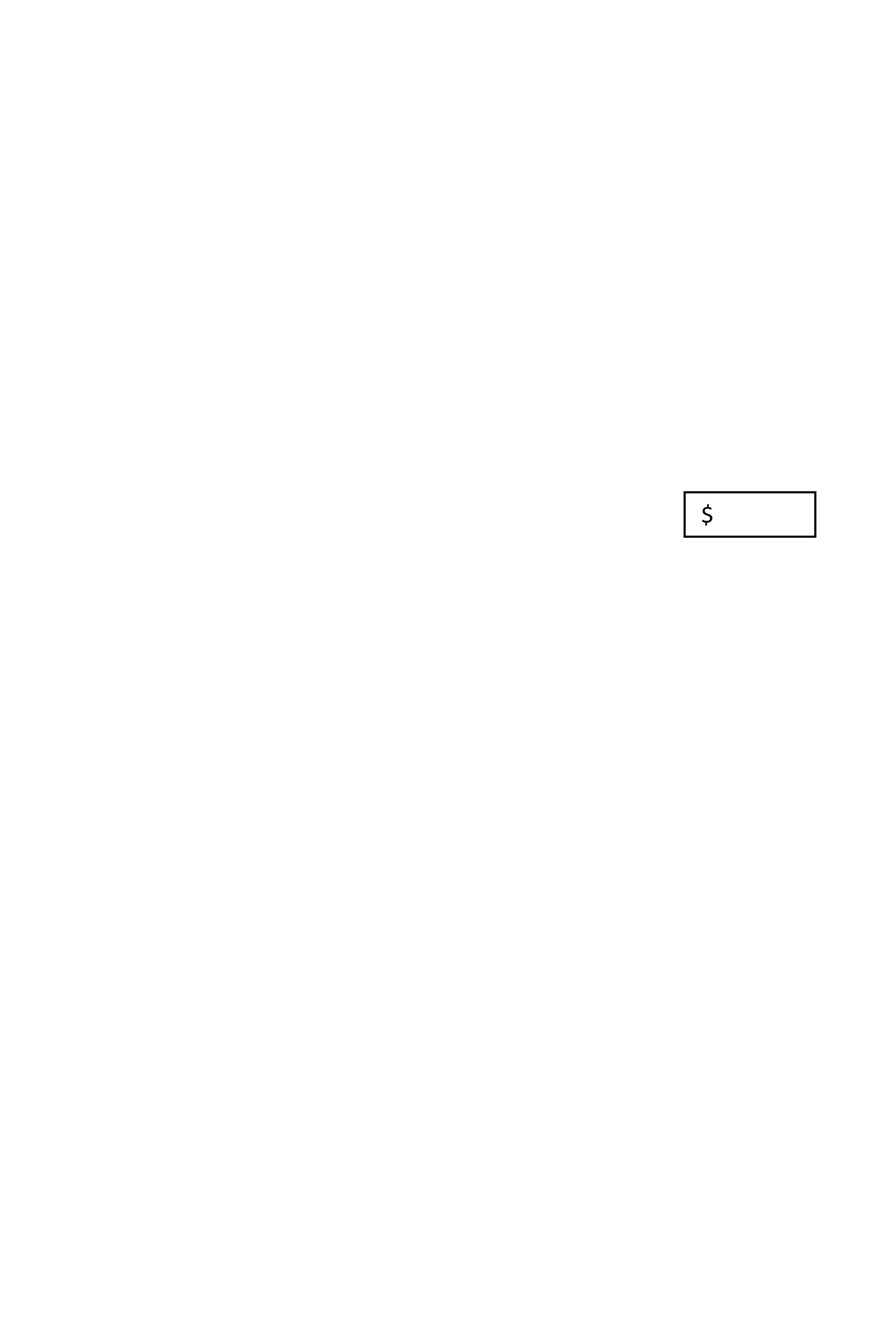
**Academic Industry**

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

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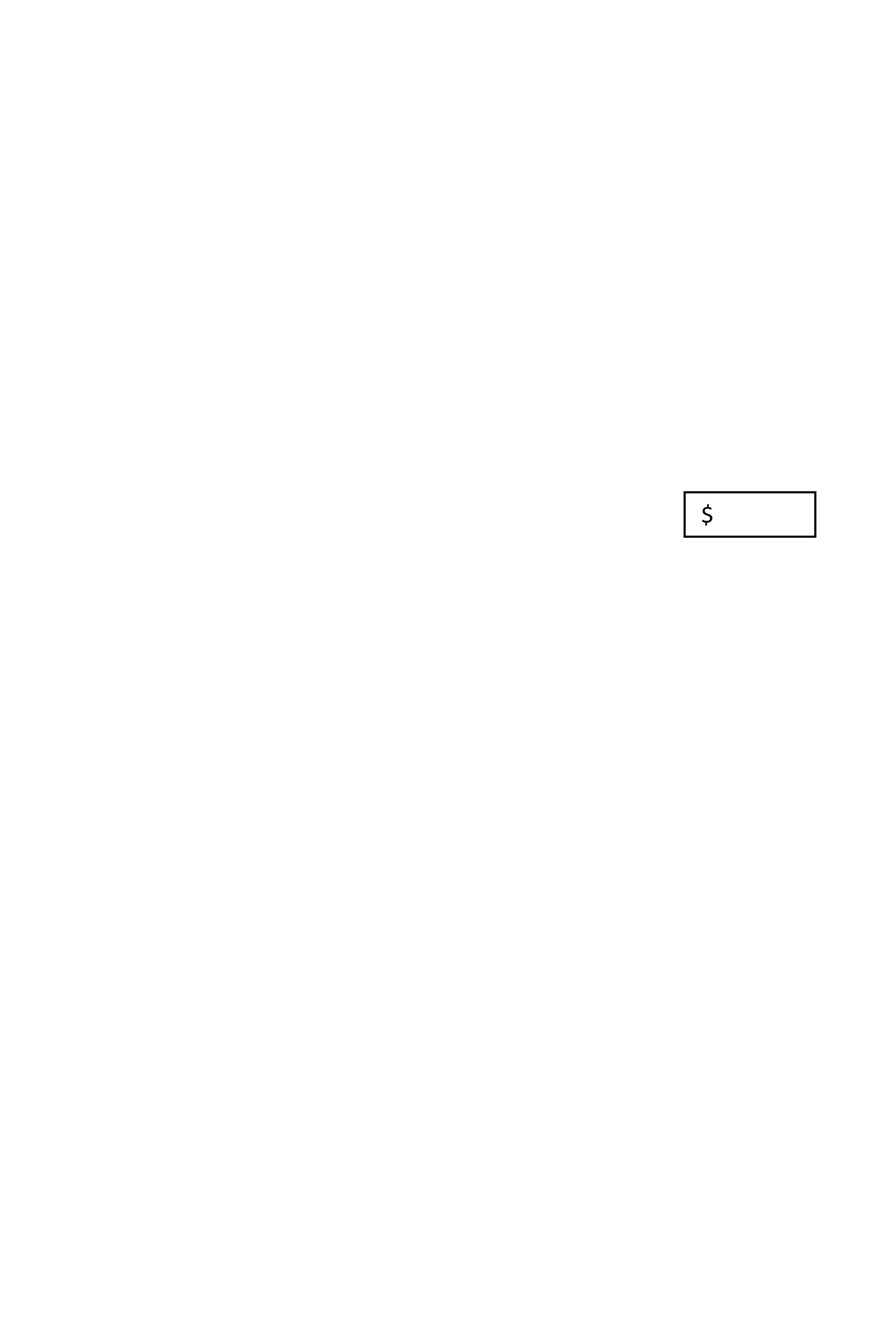
REB application  Yes  No If yes, how much?

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

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

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**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?