OR Research Form

Name of the Study	
Principal Investigator	
VCH Sites (Select all that apply)	☐ **VGH** ☐ **UBCH** ☐ **Other:**
Surgeons/Anaesthetist Involved	
Service	
Co-ordinator's name and telephone number	
Length of the study	
Start date of the study	
Anticipated end date of the study	
Number of participants in the study	
Confirmation and sample of special consent if required	
Confirmation and copy of final research approval letter	
Confirm where randomization to take place. In the office, in the OR, when the case is booked.	
Confirm notification if yearly renewals will be required and the dates of these renewals	
Confirm if any implants or instruments/ products are required. If YES:	**Yes** **No**
Provide Vendor Name - Contact name and telephone number	
Provide HPB approval or CSA approval (if applicable)	
Provide a complete list of implants and instruments with catalogue numbers and pricing	
Confirm if the device(s) will be coming for each case or what arrangements will be made for the delivery of the devices	
Confirm if the device(s) are expected to be stocked in the OR	
Confirm if there is any nursing/ssd/clerical time involved with these studies and specify what would be required	
Confirm if there are any specimens being collected, if so, how (type of container, how many), where are the specimens being sent and type of form to complete	
Provide a follow up report of the outcomes of these studies	
Provide written notification when a study has been completed, so we can remove from our active list	
PLEASE NOTE - all devices used in patients must be documented	