MossRehab

Research Resources utilization

|  |  |  |
| --- | --- | --- |
|  | **Date submitted** |  |
| 1. | Title of Project: |  |
|  |
| 2. | Principal Investigator name: |  |
|  | Primary institutional affiliation: |  |
|  | Position at primary institution: |  |
|  | Position at MossRehab: |  |
|  | Office mailing address: |  |
|  | E-mail Address: |  |
|  | Contact number: |  | Fax: |  |
|  | Signature: |  |
| 3. | Responsible Co-Investigator |
|  | Co-Investigator name: |  |
|  | Primary institutional affiliation: |  |
|  | Position at primary institution: |  |
|  | Position at MossRehab: |  |
|  | Office mailing address: |  |
|  | E-mail Address: |  |
|  | Contact number: |  | Fax: |  |
|  | Signature: |  |
| 4. | Estimated Overall Duration: | From: |  |  | To: |  |
| 5. | Patient Population Desired: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_Proposed funding: |
|  | Amount: |  |
|  | Funding Source: |  |
|  | Other sources (list sources and give dollar amounts and duration of funding for each): |
|  |  |
|  |  |

**MRRI Administration Review/Approval:**

My signature indicates that the proper notifications and consultations necessary for this research application have occurred, to the best of my knowledge.

Kevin Whelihan, MRRI Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Budget Worksheet

|  |
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| **Note: A budget must be submitted with all proposals. You may substitute a sponsor-required form. Small projects conducted with donated time can write $00 in relevant columns. \*For expedited proposals, no PRC funds should be requested*.*** |

|  |  |
| --- | --- |
| Principal Investigator:  |  |
| Detailed budget (direct costs only for first 12-month budget period: | From: |  | To: |  |

 Is the project’s budget greater than 12 months? \_\_\_\_YES \_\_\_\_NO

 PERSONNEL:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | Role in Project | Source of Funding: | % Time | Salary | Fringe Benefits | Totals |
| MRRI | Other (specify) |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Subtotal**: |  |
| Consultant Costs: |  |
| Equipment (itemize): |  |
| Supplies (itemize by category): |  |
| Travel: |  |
| Subject Reimbursement Cost: |  |
| Space Rental (indicate location, rate, and duration of period): |  |
| Other Expenses (e.g. laboratory costs, media services; itemize by category): |  |
| **Total direct costs for first 12-month budget period:** |  |

**BUDGET JUSTIFICATION:** Use the following space to explain and justify all major expenditures, which are not self-evident from the research plan: (use additional pages if necessary).

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| Program Resources Utilization |
| FOR STAFF AND SPACE |
| To the P.I. –* Complete applicable portions for each program involved with your study.
* Contact MRRI Administrator for list of active and pending studies for the specific programs affected.
* Attach list to form for your review with Program Director(s) prior to obtaining signature(s).
 |
|  |
|  |
| To the Program Director(s) – I acknowledge that the above-named study is in keeping with the mission of my clinical program. It is understood that approval of this project by the Peer Review Committee and IRB does not negate the necessity of obtaining approval from other staff members at MossRehab whose jurisdiction may be affected by the research. I have received a list of active and pending studies for my approval. |
| Program  |  |  |
|  |
|  |  | Staff |  |  |  | Space |  |  |  | Other |  |
|  |  |  |  |  |
|  | (Signature – Program Director) |  | (Date) |  |
| I acknowledge that the above-named study is in keeping with the mission of my clinical program. It is understood that approval of this project by the Peer Review Committee and IRB does not negate the necessity of obtaining approval from other staff members at MossRehab whose jurisdiction may be affected by the research. I have received a list of active and pending studies for my approval. |
| Program |  |  |
|  |
|  |  | Staff |  |  |  | Space |  |  |  | Other |  |
|  |  |  |  |  |
|  | (Signature – Program Director) |  | (Date) |  |
| I acknowledge that the above-named study is in keeping with the mission of my clinical program. It is understood that approval of this project by the Peer Review Committee and IRB does not negate the necessity of obtaining approval from other staff members at MossRehab whose jurisdiction may be affected by the research. I have received a list of active and pending studies for my approval. |
| Program |  |  |
|  |
|  |  | Staff |  |  |  | Space |  |  |  | Other |  |
|  |  |  |  |  |
|  | (Signature – Program Director) |  | (Date) |  |

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| --- |
| Subject Criteria – Mrri Research Registry  |
| Proposed Duration of Project: | From: |  | To: |  |  |  |
|  |  |
| I. STROKE | II. TRAUMATIC BRAIN INJURY | III. PARKINSON’S DISEASE |
|  |  | Total No. |  |  | Total No. |  |  | Total No. |
| (break down the total no. under each subset of boxes below\*) | (break down the total no. under each subset of boxes below\*) | (break down the total no. under each subset of boxes below\*) |
|  | Source |  | Source |  | Diagnosis |
|  |  | Inpatients only |  |  | Inpatients only |  |  | Parkinson’s Disease |
|  |  | Outpatients only |  |  | Outpatients only |  |  | Other |  |  |
|  |  | Total from both Inpatient and Outpatient pools |  |  | Total from both Inpatient and Outpatient pools |  |  |  |
|  | Subtype |  | Subtype |  | Subtype |
|  |  | Tremor-dominant |
|  |  | Left hemisphere |  |  | Closed Head Injury |  |  | Akinetic-Rigid, Posture/Gait Difficulty |
|  |  | Right hemisphere |  |  | Penetration Injury |  |  | Mixed |
|  |  | Bilateral |  |  |  |  | Other |  |  |
|  |  | Other |  |  |  |  |  |  |  |
|  | Time post onset |  | Time post onset |  | Timing/Severity |
|  |  | Early (Hoehn/Yahr 1-2) |
|  |  | 0-3 months |  |  | 0-6 months |  |  | Mid (Hoehn/Yahr 3) |
|  |  | > 3 months |  |  | > 6 months |  |  | Late (Hoehn/Yahr 4-5) |
|  | Inclusion Requirements (check as many as are relevant) |  | Inclusion Requirements (check as many as are relevant) |  |  |  |
|  | Inclusion Requirements (check as many as are relevant) |
|  |  | Aphasia |  |  | Behavioral dysfunction |  |  | DBS | Yes: |  | No: |  |  |
|  |  | Apraxia |  |  | Motor dysfunction |  |  | Apathy/Mood dysfunction |
|  |  | Cognitive involvement |  |  | Cognitive/language impairment |  |  | Cognitive involvement |
|  |  | Frontal/executive dysfunction |  |  |  |  | Fatigue |
|  |  | Hemiparesis/motor dysfunction |  | Specialty Programs |  |  | Motor dysfunction (unilateral) |
|  |  | Memory problems |  |  | Minimally Responsive |  |  | Motor dysfunction (bilateral) |
|  |  | Neglect/spatial |  |  | Neuro-Orthopaedic  |  |  | Tremor |
|  |  | Other |  |  |  |  |  |  |  | Bradykinesia |
|  | Severity Level |  | Severity Level |  |  | Memory problems/dementia |
|  |  | Speech/Swallowing |
|  |  | Severe |  |  | Severe |  |  | Other |
|  |  | Moderate |  |  | Moderate |  |  |  |
|  |  | Mild |  |  | Mild |  |  |  |
|  |  |  |  |  |

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| Subject Criteria – Mrri Research Registry |
| (continued) |
|  |
| III. ESTIMATED TIME DEMAND PER SUBJECT |
|  | INPATIENT | OUTPATIENT |
|  |  | Total # sessions |  |  | Total # sessions |
|  |  | Session length (minutes/hours) |  |  | Session length |
|  |  | # weeks |  |  | # weeks |
|  |  | 1 time only |  |  | 1 time only |
| Comments |  | Comments |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |
| IV. ADDITIONAL QUESTIONS PERTAINING TO SUBJECT AVAILABILITY |
| Will you accept patients with a history of multiple strokes in the same hemisphere?  |
|  |  |  Yes |  | No |  | N/A |
| Will you accept patients with multiple strokes in both hemispheres? |
|  |  | Yes |  | No |  | N/A |
| Can patients participate in other studies while they are enrolled in your project? |
|  |  | Yes |  | No |
|  | If yes to the previous question, please specify if there are any limitations to the type of study that is |
|  | acceptable (e.g. non-treatment/intervention only). |
|  |  |  |
|  |  |  |
|  |  |  |
| V. Will you be recruiting neurologically healthy controls? \_\_\_\_\_\_\_Yes (indicate total #) \_\_\_\_\_\_\_NoIf yes, please note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (age range in years), \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (education range in years)VI. Where can your project be run (check all that apply)? |
|  |  | Elkins Park site only |  |  | Either Elkins Park or Tabor Road |
|  |  |
|  |  | Tabor Road site only |  |  | Home visits are possible |
|  |  |
|  |  | Off site location (e.g. AEMC satellite or other hospital). Please specify below: |
|  |  |  |
| Are you willing and able to cover excess transportation costs (e.g. cab fare) if needed by Outpatients/Controls to  |
| participate? |
|  |  | Yes |  | No |
|   |

Subject Criteria – Mrri Research Registry

(continued)

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|  |
| SUMMARY RESPONSE to be completed by INVESTIGATORPlease add any additional comments here:[ ]  This study will NOT utilize the MRRI Research Registry.===========================================================================================SUMMARY RESPONSE to be completed by MRRI RESEARCH REGISTRY |
|  |  | FULL SUPPORT: The MRRI Research Registry enrollment (and staffing) should be sufficient  |
|  | **to support subject recruitment for this study.** |
|  |
|  |  | LIMITED SUPPORT: The MRRI Research Registry enrollment (and/or Registry staffing) is limited |
|  | **to assist with recruitment for this project due to:** |
|  |  | **Limited number of subjects meeting inclusion criteria.** |
|  |  |
|  |  |  | **High demand for these subjects from other studies.** |
|  |
|  |  | **This study has NO IMPACT on MRRI Research Registry enrollment or staff resources.**  |
|  |
| **Note on recruitment plan:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Date:** |  |  | **Registry Staff:** |  |  |
|  |