

**CABRINI RESEARCH GOVERNANCE**

**PROJECT RESOURCING AND COSTING TEMPLATE**

**If you have HREC approval from another site and seek governance approval at Cabrini, you need to provide a completed Cabrini Application Form (Attachment 2). Please complete this form if you require resources from other departments for your research (if costs are involved) or provide support email from each department head.**

**Please delete any sections not relevant to your project.**

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| **1.** | **PERSONNEL** | | | | |
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| **1.1** | **Principal Investigator** | | | |
| **Name and address:** | | | | |
| **Department:**  **Extension:** | | | **Database code (office use):** | |
| **Cabrini-accredited Medical Practitioner, staff, or student?** | | | | |
| **If a student is involved, who is the supervisor?** | | | | |
| **Telephone: ( )**  **Fax: ( )** | | **Email:** | | |
| **1.2** | **Primary contact** | | | |
| **Name and address:** | | | | |
| **Department:**  **Extension:** | | | | |
| **Telephone: ( )**  **Fax: ( )** | | **Email:** | | |
| **1.3** | **Study co-ordinator (to receive accounts)** | | | |
| **Name and address:** | | | | |
| **Department:**  **Extension:** | | | | |
| **Telephone: ( )**  **Fax: ( )** | | | **Email:** | |
| **1.4** | **Sponsor** | | | |
| **Sponsor company:** | | | | |
| **Contact name and address:** | | | | **ABN:** |
| **Telephone: ( )**  **Fax: ( )** | | | **Email:** | |
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| 2. | PROJECT INFORMATION | | | | |
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| 2.1 | Study Title | | | |
|  | | | | |
| **Study phase:** | | | **Proposed enrolment target:** | |
| **Estimated start date:** | | | **Estimated completion date:** | |
|  | | | **Number of weeks patient on study:** | |
| 2.2 | Study drugs (please list all drug names at each phase of the study) | | | |
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| 2.3 | **Treatment arms** | | | |
| Details (please include treatment schedule – refering to protocol): **Proposed number of patients recruited to this arm:**  (please repeat for each arm) | | | | |
| Details (please include treatment schedule): | | | | |
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| 3. | CABRINI RESOURCES | | | |
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| Does your study require any of the following resources? Please ask the department head to sign: | | | |
|  | Emergency department services | | |
| no. of patients | | | Cost per patient: $ |
| **Department Head (name):**  **Signed: Date:** | | | |
|  | **Inpatient services** | | |
| no. of patients | | | Cost per patient: $ |
| **Department Head (name):**  **Signed: Date:** | | | |
|  | **Hotel services** | | |
| no. of patients | | | Cost per patient: $ |
| **Department Head (name):**  **Signed: Date:** | | | |
|  | **Pastoral services** | | |
| no. of patients | | Cost per patient: $ | |
| **Department Head (name):**  **Signed: Date:** | | | |
| **Clinical Governance Unit services** | | | |
| no. of patients | | | Cost per patient $ |
| **Department Head (name):**  **Signed: Date:** | | | |
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|  | **INSTITUTE RESOURCES** | | | | |
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| **Estimated time required of manager** (supervision, audits)**:**  hours for weeks Total: | | | | |
| **Estimated time required of study co-ordinator** (initial screening, physical exam [including vitals, medical history, quality of life questionnaire], monitoring, data entry, audits)**:**  hours for weeks Total: | | | | |
| **Number of additional staff:** | | **Expected duration of employment:** | | |
| **Hours expressed as FTE:** | | **Salary rate (p/a for 1.0FTE):** | | |
| **Archiving cost** (boxes, storage, retrieval, secure destruction)**:** | | | | |
| **Supplies:** | | | | **Cost:** |
| Biostatistician ($75 per hour) | | | |  |
| Stationery/photocopying/printing | | | |  |
| Catering (for project meetings) | | | |  |
| IT requirements (e.g.: software & hardware requirements, internet usage) | | | |  |
| Legal fees | | | |  |
| Equipment requirements (e.g.: storage facilities for drugs and/or confidential information) | | | |  |
| Publishing costs | | | |  |
| Other (please specify) | | | |  |
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| **Patient travel reimbursements:**  metropolitan: $ per km | | rural: $ per km | | |
| **Overhead charge** (IT, Finance, HR, insurances, etc.)**:** | | | | |
| **Schedule of study audit** (e.g. quarterly, annually)**:** | | | | |
| **Please detail any grant applications made to fund this study:** | | | | |
| **Funding Body** | **Grant submission** | | **Outcome**  (S) Successful (U) Unsuccessful  (P) Pending *(please specify expected date of decision)* | |
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| **Please specify how the study conforms with the requirements of the Cabrini Institute Strategic Plan:** | | | | |
| **Comments:** | | | | |
| **Department Head (name):**  **Signed: Date:** | | | | |

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|  | **MEDICAL IMAGING** | | | | | | |
|  |  | | | | | | |
| **Details**  (Please list all tests required, adding more rows where necessary) | | **Item no.** | **No. reqd.** | **Std. of care**  Y/N | **Radiation class** | **Cost** | **To be paid by** (S) Sponsor (I) Insurer  (P) Patient (C) Cabrini |
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| **Radiation safety officer reporting requirements:** | | | | | | |
| **Comments:** | | | | | | |
| **Department Head (name):**  **Signed: Date:** | | | | | | |

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|  | **Health Information Services Resources** | | | |
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| **Details**  (Please include more details where required, or add more rows) | | **No. reqd.** | **Cost** | **To be paid by**  (S) Sponsor (I) Insurer  (P) Patient (C) Cabrini |
| Retrieval of medical records | |  |  |  |
| Archiving of medical records | |  |  |  |
| Reporting – generation of reports | |  |  |  |
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| Limited space is available in HIS for the review of medical records | | | |
| **Comments:** | | | |
| **Department Head (name):**  **Signed: Date:** | | | |

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|  | **PATHOLOGY** | | | | | | |
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|  | **Pay category (Pathology office use):** | | | | | | |
| **Details**  (Please list all tests required, adding more rows where necessary) | | **Item no.** | **No. reqd.** | | **Std. of care**  Y/N | **Cost** | **To be paid by**  (S) Sponsor (I) Insurer  (P) Patient (C) Cabrini |
| Trial handling | | 11190 |  | |  |  |  |
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| **Preparation regime:**  IV medication:  Oral medication: | | | | | | |
|  | **Type of service (please highlight):**  **Self-collecting:** | | | **Collection by Cabrini Pathology:** | | | |
|  | **Transport required:** | | | | | | |
| **Comments:** | | | | | | |
| **Department Head (name):**  **Signed: Date:** | | | | | | |

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|  | **PHARMACY RESOURCES** | | | | | | | | |
|  | Fees are subject to review and pharmacy reserves the right for increase on the 1st January of each calendar year. | | | | | | | | |
| **Start up fee:** $ | | | | **Annual fee:** $ | | | | |
| **Call out fee:** $ | | | | **Close out fee:** $ | | | | |
| **Refrigerator temperature annual storage fee:** $ | | | | **Room temperature annual fee:** $ | | | | |
| **Freezer temperature annual storage fee:** $ | | | | | | | | |
| **Details**  (Please list all tests required, adding more rows where necessary) | | **Item no.** | **No. reqd.** | | | **Std. of care**  Y/N | | **Cost** | **To be paid by**  (S) Sponsor (I) Insurer  (P) Patient (C) Cabrini |
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| **Please specify additional equipment if required** (e.g: refrigerator, freezer)**:** | | | | | | | | |
| **Estimated cost of additional equipment:** | | | **Estimated running costs p.a.:** | | | | | |
| **Who will be responsible for cost of additional equipment (please highlight)?** | | | | | | **Cabrini** | | **Sponsor** |
| **If additional equipment will be the responsibility of Cabrini, please indicate how purchase will be funded (please highlight):**  From current year’s departmental budget External grant funding  Submission made to the Capital Expenditure Committee | | | | | | | | |
| **Comments:** | | | | | | | | |
| **Department Head (name):**  **Signed: Date:** | | | | | | | | |

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|  | **cARDIORESPIRATORY RESOURCES** | | | | | |
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| **Details**  (Please list all tests required, adding more rows where necessary) | | **Item no.** | **No. reqd.** | **Std. of care**  Y/N | **Cost** | **To be paid by**  (S) Sponsor (I) Insurer  (P) Patient (C) Cabrini |
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| **Department Head (name):**  **Signed: Date:** | | | | | |

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|  | **ONCOLOGY** | | | | | | | |
|  | **Please highlight:** | | | | | | | |
|  | **Day procedure** | **Ward** | | | | **Both** | | |
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| **Details**  (Please list all tests required, adding more rows where necessary) | | | **Item no.** | **No. reqd.** | **Std. of care**  Y/N | | **Cost** | **To be paid by**  (S) Sponsor (I) Insurer  (P) Patient (C) Cabrini |
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|  | **Procedures outside normal business hours (eg: Saturday):** | | | | | | | |
| **Details** | | | **Item no.** | **No. reqd.** | **Std. of care**  Y/N | | **Cost** | **To be paid by**  (S) Sponsor (I) Insurer  (P) Patient (C) Cabrini |
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|  | **Comments:** | | | | | | | |
| **Department Head (name):**  **Signed: Date:** | | | | | | | |