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: ____________________

   Patient Population Desired: Type: ____________________ Number: __________

5. 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

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: ______________

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).

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)

SUBJECT CRITERIA – MOSSREHAB PATIENT RESEARCH REGISTRY FOR STROKE AND TBI PATIENTS

Proposed Duration of Project: From: ______________ To: ____________

I. STROKE	II. TRAUMATIC BRAIN INJURY
[ ] 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*)
Source	**Source**
[ ] Inpatients only	[ ] Inpatients only
[ ] Outpatients only	[ ] Outpatients only
[ ] Total from both Inpatient and Outpatient pools	[ ] Total from both Inpatient and Outpatient pools
Subtype	**Subtype**
[ ] Left hemisphere	[ ] Closed Head Injury
[ ] Right hemisphere	[ ] Penetration Injury
[ ] Bilateral	
[ ] Other ____________	
Time post onset	**Time post onset**
[ ] 0-3 months	[ ] 0-6 months
[ ] > 3 months	[ ] > 6 months
Inclusion Requirements (check as many as are relevant)	**Inclusion Requirements** (check as many as are relevant)
[ ] Aphasia	[ ] Behavioral dysfunction
[ ] Apraxia	[ ] Motor dysfunction
[ ] Cognitive involvement	[ ] Cognitive/language impairment
[ ] Frontal/executive dysfunction	
[ ] Hemiparesis/motor dysfunction	**Specialty Programs**
[ ] Memory problems	[ ] Minimally Responsive
[ ] Neglect/spatial	[ ] Neuro-Orthopaedic
[ ] Other ____________	
Severity Level	**Severity Level**
[ ] Severe	[ ] Severe
[ ] Moderate	[ ] Moderate
[ ] Mild	[ ] Mild

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 ____________

SUBJECT CRITERIA – MOSSREHAB PATIENT RESEARCH REGISTRY FOR STROKE AND TBI PATIENTS

(continued)

IV. ADDITIONAL QUESTIONS PERTAINING TO SUBJECT AVAILABILITY

Will you accept patients with a history of multiple strokes in the same hemisphere?

☐ Yes ☐ No

Will you accept patients with multiple strokes in both hemispheres?

☐ Yes ☐ No

Can patients participate in other studies while they are enrolled in your project?

☐ Yes ☐ No

If yes to the previous question, please specify whether or not there are any limitations to the type of study that is acceptable (e.g. non-treatment/intervention only).

____
____
____

Where can your project be run? (check as many as 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 in order to participate?

☐ Yes ☐ No

MOSS REHAB PATIENT REGISTRY RESPONSE

☐ **FULL SUPPORT: The Moss Rehab Patient Registry enrollment (and staffing) should be sufficient to support subject recruitment for this study.**

☐ **LIMITED SUPPORT: The Moss Rehab Patient 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 Moss Rehab Patient Registry enrollment or staff resources.**

Note on recruitment plan:

____
____
____
____

Date: ______________________ **Reviewer:** ______________________