

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):

MRI 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, MRI 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
		MRRRI	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: _____

<p>I. STROKE</p> <div style="text-align: right; margin-bottom: 10px;"> <input style="width: 50px; height: 20px; border: 1px solid black;" type="text"/> Total No. </div> <p>(break down the total no. under each subset of boxes below*)</p> <p>Source</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Inpatients only <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Outpatients only <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Total from both Inpatient and Outpatient pools <p>Subtype</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Left hemisphere <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Right hemisphere <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Bilateral <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Other _____ <p>Time post onset</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> 0-3 months <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> > 3 months <p>Inclusion Requirements (check as many as are relevant)</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Aphasia <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Apraxia <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Cognitive involvement <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Frontal/executive dysfunction <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Hemiparesis/motor dysfunction <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Memory problems <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Neglect/spatial <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Other _____ <p>Severity Level</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Severe <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Moderate <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Mild	<p>II. TRAUMATIC BRAIN INJURY</p> <div style="text-align: right; margin-bottom: 10px;"> <input style="width: 50px; height: 20px; border: 1px solid black;" type="text"/> Total No. </div> <p>(break down the total no. under each subset of boxes below*)</p> <p>Source</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Inpatients only <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Outpatients only <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Total from both Inpatient and Outpatient pools <p>Subtype</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Closed Head Injury <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Penetration Injury <p>Time post onset</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> 0-6 months <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> > 6 months <p>Inclusion Requirements (check as many as are relevant)</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Behavioral dysfunction <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Motor dysfunction <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Cognitive/language impairment <p>Specialty Programs</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Minimally Responsive <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Neuro-Orthopaedic <p>Severity Level</p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Severe <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Moderate <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> Mild
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III. ESTIMATED TIME DEMAND PER SUBJECT	
INPATIENT	OUTPATIENT
<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> Total # sessions <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> Session length (minutes/hours) <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> # weeks <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> 1 time only Comments _____	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> Total # sessions <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> Session length <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> # weeks <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> 1 time only 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: _____