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| **Northern Ireland Clinical Research Facility (NICRF)**  **BLOOD SAMPLING ONLY FORM** |

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| Please complete this form as fully as possible (boxes will expand to permit full answers). Without these details we will be unable to process your application. Please send your completed application form, along with the supporting documentation to [NICRF@belfasttrust.hscni.net](mailto:NICRF@belfasttrust.hscni.net) . Please contact us on (028) 95040342 if you require assistance and additional information is available on our website [www.qub.ac.uk/nicrf](http://www.qub.ac.uk/nicrf) . Please refer to “User Guide for Blood Sampling Only Applications” on website. |

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| **1. PROJECT DETAILS** |

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| **Project Title:** *[As used in Research Governance]*  *Enter the complete study title in this section.* | |
| **Short Title:**  (acronym) | *[The name you will use for bookings]* |
| **Lay Summary (150-200 words max)**  *Include:*   1. *What is the problem being addressed* 2. *Why is it important* 3. *What is the research question/aim* 4. *Design & methods* 5. *PPI Involvement*   *[Please note the Lay Summary will be displayed on our website]* | |

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| **Research Team :** (*Include all relevant team members with full contact details)*  **Please asterisk\* who will be point of contact** | | | | |
| **Principal/Chief Investigator :** | **E-Mail Address:** | **Employer:** | **Postal address:** | **Telephone number:** |
| **Research Team:** |  |  |  |  |
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| **Participants** | | | | |
| Number of participants who will attend the NICRF and number of blood samples:  *If possible give exact numbers. If exact numbers are not clear then give an estimate.*  *Include a breakdown of numbers for each treatment arm where there is more than one.* | | |  | |
| Are participants patients or healthy volunteers  *Enter patient or participant as applicable* | | |  | |

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| **2. FUNDING DETAILS** |

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| **Sponsor:** | |
| **Which Institution is providing governance / sponsor approval?**   * **BHSCT If joint, tick appropriate boxes** * **UU** * **QUB** | **Has research governance sponsorship been confirmed?**  *Yes / No / pending* |
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| **3. NICRF RESOURCES** | |
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| **When do you plan to commence using the NICRF?**  *Enter date or anticipated quarter: Q1 (Jan-March), Q2 (April-June), Q3 (July-Sept), Q4 (Oct – Dec)* | |
| **How long do you plan to use it for?**  *Estimated final date based on end of recruitment and participant schedule.*  ***Please tick requirement:***   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Space / Staff** | **Y** | **N** | **Equipment / Consumables** | **Y** | **N** | | Clinical rooms |  |  | Non- MR Imaging (ECHO) |  |  | | NICRF Laboratory \* |  |  | Dexa Scanner |  |  | | Sample Storage \* |  |  | Bronchoscopy |  |  | | Nursing Support \* |  |  | ECG |  |  | |  |  |  | Lung Clearance Index (LCI) |  |  | |  |  |  | Other Consumables \* |  |  | |  |  |  | Basics/consumables/butterflies/ tourniquet and blood bottles, available in NICRF |  |  |  |  | | --- | | ***Please indicate details of visits, duration and include a list of required resources for each study visit***  ***(Refer to example of completed application) for further information.***  Day 1 – 8 hours – ECG. ECHO, Spirometry, DEXA  Day 15 – 8 hours – No equipment  Week 4 – 6.5 hours – No equipment  Week 8 – 5 hours – No equipment  Week 16 – 5.5 hours – No equipment  Week 24 – 8 hours (Slit lamp, OCT, ECG, Auto-Refractor, Spirometry – out of hours required)  Week 36 – 5 hours - no equipment  Week 48 – 7 hours - (Slit lamp, OCT, ECG, Auto-Refractor, Spirometry – out of hours required)  Week 60 – 5 hours – no equipment  Week 72 – 5 hours – no equipment  Week 84 – 5 hours – no equipment  Week 96 – 8 hours – ECG, echo, Spirometry, Dexa  Early Termination – 8 hours  Safety Follow-up – 8 hours | | |