Tufts | CTSI

Tufts Clinical and Translational Science Institute

Clinical and Translational Research Center (CTRC)
Service and Budget Requisition Form

Instructions:

1. In the fields below, please fill in as much as you can below. If you wish to arrange a time to discuss the protocol in person with us, please indicate here and we will be in touch to arrange a time ☐

2. Attach the following documents with this completed form:
   1. Study Protocol, 2. Lab Manual. If you only have draft forms, please indicate that in the document title.

3. If you have not done so please submit your request through the link below for tracking purposes:
   https://tuftsctsi.my.site.com/s/

Please contact CTRCmanagement@tuftsmedicine.org for questions. We are available to discuss the specific needs of your study either in-person or virtually and we can be contacted at CTRCmanagement@tuftsmedicine.org or 617-636-4714 to find a time. Alternatively, please drop by the CTRC Clinic in North 6.

Table 1: Study Intake	
Full Study Title**:**	
Short title:	
Principal Investigator (PI):	
Institution (TMC/TU):	☐ Tufts Medical Center ☐ Lowell General Hospital ☐ Melrose Wakefield Hospital ☐ Tufts University ☐ School of Medicine ☐ School of Dental Medicine ☐ Friedman School of Nutrition ☐ Other (fill in)
Division/department:	
Primary Study Contact:	
Research Administrator:	
Will CTRC be the primary study coordinator for this study?	Yes ☐ No ☐ Not sure, would like to discuss ☐ If no, please provide name of study coordinator:
Status of IRB:	☐ Not started ☐ In progress ☐ Submitted ☐ Approved; IRB #_____
Name of IRB:	☐ Tufts HS ☐ Advarra ☐ WCG ☐ Other:
Is the PI new to TMC/TU/clinical trials or need additional senior-level CTRC support for any reason?	☐ Yes, specify: _____ ☐ No

Multi-center trial?	☐ Tufts only ☐ Multi-center Number of sites planned: _____ If investigator-initiated, the coordinating center will be: ☐ Tufts Medical Center ☐ Other – please specify: _____

Table 2: Funding status *Fill in one side of the table*	
☐ Grant application	☐ Funded
Industry ☐ Federal ☐ Foundation ☐ Other ☐	Industry ☐ Federal ☐ Foundation ☐ Other ☐
	Investigator initiated ☐ Sponsored ☐
Sponsor Name (if applicable):	Sponsor Name (if applicable):
Deadline for budget development	Deadline for budget development
Indicate grant deadline _____ (MM/DD/YYY)	*Indicate deadline _____ (MM/DD/YYY)*
Indicate deadline for submission to research administration _____ (MM/DD/YYY)	
Indicate if preliminary budget estimate within 2 to 3 day period is needed for planning ☐	

Table 3: Study Development Services		
Service Type	**Yes/ NA**	**Specifics or comments**
Protocol Development	Yes ☐ No ☐	
IRB Preparation	Yes ☐ No ☐	
Recruitment services and planning	Yes ☐ No ☐	

Table 3: Study level details and participant visits	
Location of Study Activities Performed by CTRC Staff	
Location of study activities: *Please select all that apply.*	☐ CTRC Clinic ☐ Inpatient hospital rooms ☐ ICU ☐ Outpatient procedure area (i.e. Interventional Radiology, Cath lab, etc.) ☐ Tufts MC Adult Clinics ☐ Tufts MC Pediatric Clinics ☐ Melrose Wakefield Hospital ☐ Lowell General Hospital *If other, please specify*_____
Estimated trial duration	Years =

Target enrollment at Tufts	n= *if not sure, please indicate approximate range (eg 1-2, 5 to 10, > 100)*

Patient Services by CTRC staff *If you are not sure about which of the following are needed or if this will be CTRC-managed study, please indicate here and we can be in touch with you* ☐		
Specialized Vital Signs	Yes ☐ No ☐	
Informed Consent	Yes ☐ No ☐	Specify if virtual ☐
Height/Weight	Yes ☐ No ☐	
Electrocardiogram (EKG)	Yes ☐ No ☐	
Phlebotomy	Yes ☐ No ☐	
Blood Draw via IV Line	Yes ☐ No ☐	
Sample Processing	Yes ☐ No ☐	
Sample Shipping (Local vs. Central)	Yes ☐ No ☐	Local ☐ Central ☐
Post Study Drug Observation	Yes ☐ No ☐	
Concomitant Medication Reconciliation	Yes ☐ No ☐	
Adverse Event (AE) Assessment	Yes ☐ No ☐	
Short term Sample Storage	Yes ☐ No ☐	
Long term Sample Storage and Archiving	Yes ☐ No ☐	
Anticipate visits outside Mon- Fri. 8am-5pm	Yes ☐ No ☐	
Data Entry	Yes ☐ No ☐	
Auxiliary services (i.e., OGTT, CGM installation, 6-minute walk test) or specialized equipment; *please specify*		
Questionnaires or surveys *If yes, please specify name and approximate length of time required to complete each individual assessment tool:*	Yes ☐ No ☐	
Please provide any additional comments or requests here:		