Clinical Research Center (CRC) Cost Estimate Request

***NOTE: This form is used for budget purposes. This is not the application to use CRC services.***

**ALL ITEMS MUST BE COMPLETED**

1. General Information

* 1. **Study Title:**

**1.2** **Principal Investigator:**

 Name:

 Phone:

 E-Mail:

**1.3** **Contact Person for Cost Estimate:**

 Name:

 Phone:

 E-Mail:

1. **Source of Funding/Sponsorship**

 Check all appropriate boxes for funding/sponsorship for this research.

 [ ]  Department Funding

 [ ]  Industry Sponsored / Investigator-Initiated

 [ ]  Government Agency

 [ ]  Foundation

 [ ]  Other:

**3. CRC Need:**

 Please indicate **WHY** CRC resources are needed:

4. Participant Projections

**4.1** Projected start date:

**4.2** Expected duration of study from initial enrollment to completion of last subject:      year(s)

**4.3** Please project the number of ***NEW*** subjects for each year (June 1st to May 31st) and then provide the total number for the duration of the study.

 Inpatient Outpatient

1st year

2nd year

3rd year

4th year

Total:

**4.4** Are subjects to be studied as inpatients on the CRC (i.e. will the subject be in a CRC bed at midnight)?

 [ ]  Yes [ ]  No

 **If Yes, per subject**: number of days per admission on the CRC:

 Number of admissions on the CRC:

**4.5** Are outpatient visits on the CRC included in study?

 [ ]  Yes [ ]  No

 **If Yes, per subject**: number of visits on the CRC:

 Approximate length of visit on the CRC:       hours

5. CRC SERVICES

Please indicate if the following services are needed:

**5.1 Nursing Services:**

[ ]  Yes [ ]  No

**If YES,** check all that are needed:

[ ]  Routine patient care (i.e. ht, wt, vital signs)

[ ]  Special cardiac monitoring (Telemetry)

[ ]  ECG

[ ]  Biopsies Type of Biopsy:

[ ]  Non-serial blood collections

[ ]  Serial blood collections

[ ]  IV lines

[ ]  Subcutaneous injections/teaching

## [ ]  IV infusions

[ ]  24 hour urine collections

[ ]  Stool collections

[ ]  Only blood draw and processing

[ ]  Other:

**5.2 Other Services**:

[ ]  Yes [ ]  No

 **If YES**, Indicate the service, the # of subjects or patients and the # of tests per subject:

      # of subjects       # of tests /subject

**5.3 Bionutrition:**

## Are regular meals or snacks needed? (check yes for meals post fasting, visits >4 hours, and

 overnight) [ ]  Yes [ ]  No

**5.3.1 Bionutrition Services (other than regular meals or snacks)**

 [ ]  Yes [ ]  No

**If YES,** check all that are needed:

[ ]  Standardized meals (check yes if any food/nutritional manipulation is necessary)

[ ]  Metabolic or constant diet (weighed)

[ ]  Pre-admission counseling for dietary control (e.g., high carbohydrate diet prior to OGTT)

[ ]  Patient nutrition counseling/education

[ ]  Other (e.g., find appropriate nutrition assessment tools):

**5.4 Laboratory Services:**

[ ]  Yes [ ]  No

**If YES,** check the services needed:

[ ]  Processing only # of potential samples      length of storage duration

[ ]  Freezer space # of potential samples      length of storage duration

**5.4.1** Is special handling of samples required?

[ ]  Yes [ ]  No

**If YES**, please explain:

Other: