Statement of Clinical Research Impact on VA Hospital Services

1. **Principal Investigator/Program Director:** _____
   Last ***First*** ***MI*** ***Degree***

2. **Project Title:** _____
   (Maximum length = 142 characters, including spaces)

3. **Name of Sponsor:** _____
   Administered By: ☐ **VA** ☐ **Biomedical Research Foundation of South Texas** ☐ **UTHSCSA** ***(Check one)***
   ☐ **Other** _____

4. **UTHSCSA IRB Number:** _____

5. **Anticipated Starting Date:** ____/ / ____ ***(mm/dd/yy)*** **Anticipated Ending Date:** ____/ / ____ ***(mm/dd/yy)***

6. **Number of Subjects:** **Total enrolled at STVHCS:** **Veterans enrolled at STVHCS:** **Non-Veterans enrolled at STVHCS:**
   Inpatients: **Inpatients:**
   Outpatients: **Outpatients:**

7. **GCRC Being Used:** ☒ **Yes** ☐ **No** ***(Check one)***

8. **Procedures Beyond Routine Clinical Care (Additional, Altered Process or Increased Frequency)**

   A. Radiology Service

Number of Patients	Number of Procedures Per Patient	Procedure	Frequency	Other Information

For Radiology use only:

Radiology Service ☐**CAN** ☐ **CANNOT accommodate the expected workload. Any limitations are attached.**

Chief, Radiology Service _____
Signature/Date of Signature

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5. **Anticipated Starting Date:** ____/ / ____ ***(mm/dd/yy)*** **Anticipated Ending Date:** ____/ / ____ ***(mm/dd/yy)***

6. **Number of Subjects:** **Total enrolled at STVHCS:** **Veterans enrolled at STVHCS:** **Non-Veterans enrolled at STVHCS:**
   Inpatients: **Inpatients:**
   Outpatients: **Outpatients:**

7. **GCRC Being Used:** ☒ **Yes** ☐ **No** ***(Check one)***

8. **Procedures Beyond Routine Clinical Care (Additional, Altered Process or Increased Frequency)**

   B. Nuclear Medicine Service

Number of Patients	Number of Procedures Per Patient	Procedure	Frequency	Other Information

For Nuclear Medicine Use only:

Nuclear Medicine Service ☐**CAN** ☐ **CANNOT accommodate the expected workload. Any limitations are attached.**

Chief, Nuclear Medicine Service _____
Signature/Date of Signature

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   Administered By: ☐ **VA** ☐ **Biomedical Research Foundation of South Texas** ☐ **UTHSCSA** ***(Check one)***
   (Check one) ☐ **Other** _____

4. **UTHSCSA IRB Number:** _____

5. **Anticipated Starting Date:** ____/ /____ ***(mm/dd/yy)*** **Anticipated Ending Date:** ____/ /____ ***(mm/dd/yy)***

6. **Number of Subjects:** **Total enrolled at STVHCS:** **Veterans enrolled at STVHCS:** **Non-Veterans enrolled at STVHCS:**
   Inpatients: **Inpatients:**
   Outpatients: **Outpatients:**

7. **GCRC Being Used:** ☐ **Yes** ☐ **No** ***(Check one)***

8. **Procedures Beyond Routine Clinical Care (Additional, Altered Process or Increased Frequency)**

   C. Nursing Service

Location						
Inpatient	**Clinic**	**Nurse-Administered Procedure**	**Number of Patients**	**Number of Procedures Per Patient**	**Frequency**	**Other Information**
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

For Nursing Service use only:

Nursing Service ☐**CAN** ☐ **CANNOT accommodate the expected workload. Any limitations are attached.**
Comments:

Nursing Representative for R&D Committee _____
Signature/Date of Signature

Associate Director for Patient Care Services (Nurse Executive) _____
Signature/Date of Signature

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3. **Name of Sponsor:**
   Administered By: ☐ VA ☐ Biomedical Research Foundation of South Texas ☐ UTHSCSA *(Check one)*
   (Check one) ☐ Other _____

4. **UTHSCSA IRB Number:** _____

5. **Anticipated Starting Date:** ____/ /____ *(mm/dd/yy)* **Anticipated Ending Date:** ____/ /____ *(mm/dd/yy)*

6. **Number of Subjects:** **Total enrolled at STVHCS:** **Veterans enrolled at STVHCS:** **Non-Veterans enrolled at STVHCS:**
   Inpatients: **Inpatients:**
   Outpatients: **Outpatients:**

7. **GCRC Being Used::** ☒ Yes ☐ No *(Check one)*

8. **Procedures Beyond Routine Clinical Care (Additional, Altered Process or Frequency)**

   D. Pharmacy Service

Number of Subjects	Medication	Number of Doses	Frequency	Drug Provider						Location of Drug/ Contact	Estimated cost to Pharmacy *(Pharmacy use only)*
				Veterans			Non Veterans				
				VA	Sponsor	PI	VA	Sponsor	PI		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐		

For Pharmacy use only:

Pharmacy Involvement in the above protocol will be:
- ☐ **Receipt of Drug(s)**
- ☐ **Reconstitution of Drug(s)**
- ☐ **Validation of Drug(s)**
- ☐ **Dispensing of Drug(s)**

Estimated Pharmacy expenses:
Pharmacy Administrative and labor costs: _____
Total Drug costs: _____
Total Cost: _____

Pharmacy Service ☐**CAN** ☐ **CANNOT accommodate the expected cost and workload. Any limitations are attached.**

Director, Investigational Pharmacy _____
Signature/Date of Signature

Chief, Pharmacy Service _____
Signature/Date of Signature

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3. **Name of Sponsor:** _____
   Administered By: ☐ **VA** ☐ **Biomedical Research Foundation of South Texas** ☐ **UTHSCSA** ***(Check one)***
   ☐ **Other** _____

4. **UTHSCSA IRB Number:** _____

5. **Anticipated Starting Date:** ____/ / ____ ***(mm/dd/yy)*** **Anticipated Ending Date:** ____/ / ____ ***(mm/dd/yy)***

6. **Number of Subjects:** **Total enrolled at STVHCS:** **Veterans enrolled at STVHCS:** **Non-Veterans enrolled at STVHCS:**
   Inpatients: **Inpatients:**
   Outpatients: **Outpatients:**

7. **GCRC Being Used:** ☒ **Yes** ☐ **No** ***(Check one)***

8. **Procedures Beyond Routine Clinical Care (Additional, Altered Process or Increased Frequency)**

   E. Pathology and Laboratory Service

Number of Patients	Number of Procedures Per Patient	Procedure	Frequency	Other Information

Clinical Laboratory ☐**CAN** ☐ **CANNOT accommodate the expected workload. Any limitations are attached.**

Chief, Pathology and Laboratory Service _____
Signature/Date of Signature

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3. **Name of Sponsor:** _____
   Administered By: ☐ **VA** ☐ **Biomedical Research Foundation of South Texas** ☐ **UTHSCSA** ***(Check one)***
   ☐ **Other** _____

4. **UTHSCSA IRB Number:** _____

5. **Anticipated Starting Date:** ____/ / ____ ***(mm/dd/yy)*** **Anticipated Ending Date:** ____/ / ____ ***(mm/dd/yy)***

6. **Number of Subjects:** **Total enrolled at STVHCS:** **Veterans enrolled at STVHCS:** **Non-Veterans enrolled at STVHCS:**
   Inpatients: **Inpatients:**
   Outpatients: **Outpatients:**

7. **GCRC Being Used:** ☒ **Yes** ☐ **No** ***(Check one)***

8. **Procedures Beyond Routine Clinical Care (Additional, Altered Process or Increased Frequency)**

   F. Other Procedures

Number of Patients	Number of Procedures Per Patient	Procedure	Frequency	Other Information

Section/Service ☐**CAN** ☐ **CANNOT accommodate the expected workload. Any limitations are attached.**

Chief _____
Signature/Date of Signature