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| **Community of Care *Signature Sheet*** | | | | VCH - VANCOUVER ACUTE | | |
| *SIGNATURES OF APPROVAL IS REQUIRED FROM THE RELEVANT MEDICAL/PROGRAM DIRECTOR OR MANAGER.* | | | | | | |
| **Research Project Information** | | | | | | |
| **RESEARCH STUDY TITLE** |  | | | | | |
| **REB #** |  | | | | **DATE** |  |
| **PRINCIPAL INVESTIGATOR** |  | | | |  |  |
| **PRIMARY CONTACT** |  | | | |  |  |
| **VCH DEPARTMENT** | | **COST ANALYSIS REQUIRED** | **HOSPITAL AND VCH SIGNATORY NAME** | | **SIGNATURE** | |
| **PHARMACY** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **RADIOLOGY** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **Other Medical Imaging** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **CLINICAL CHEMISTRY** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **MICROBIOLOGY** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **OPERATING ROOM** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **ANESTHESIA** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **ANATOMICAL PATHOLOGY** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **HEMATOPATHOLOGY** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **DATA & ANALYTICS** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **HEALTH RECORDS (HARD COPY)** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **VCH DATABASE:**  **(SPECIFY)** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **OTHER DATABASE: (SPECIFY)** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **CLINICAL UNIT: (SPECIFY 1-3)** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **1) CLINICAL UNIT** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **2) CLINICAL UNIT** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **Biomedical Engineer** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **OTHER RESOURCES: (SPECIFY)** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **OTHER RESOURCES: (SPECIFY)** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **OTHER RESOURCES: (SPECIFY)** | | IS COST ANALYSIS REQUIRED | VGH: ENTER VCH SIGNATORY NAME  UBCH: ENTER VCH SIGNATORY NAME | |  | |
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| **Community of Care *Signature Sheet*** | | VCH – GF STRONG REHABILITATION CENTRE | | |
| *SIGNATURE OF APPROVAL IS REQUIRED FROM THE RELEVANT MEDICAL/PROGRAM DIRECTOR OR MANAGER.*  For information on GF STRONG signatories, please contact Elaine Pozney at elaine.pozney@vch.ca or (604) 737-6208. | | | | |
| **Research Project Information** | | | | |
| **RESEARCH STUDY TITLE** |  | | | |
| **REB #** |  | | **DATE** |  |
| **PRINCIPAL INVESTIGATOR** |  | |  |  |
| **PRIMARY CONTACT** |  | |  |  |
| **VCH DEPARTMENT** | **COST ANALYSIS REQUIRED** | | **VCH SIGNATORY NAME** | **SIGNATURE** |
| **ADULT LEARNING** | IS COST ANALYSIS REQUIRED | |  |  |
| **ASSISTIVE TECHNOLOGY** | IS COST ANALYSIS REQUIRED | |  |  |
| **DATA & ANALYTICS** | IS COST ANALYSIS REQUIRED | |  |  |
| **DRIVER REHAB** | IS COST ANALYSIS REQUIRED | |  |  |
| **EQUIPMENT EVALUATION** | IS COST ANALYSIS REQUIRED | |  |  |
| **FACILITY OPERATIONS** | IS COST ANALYSIS REQUIRED | |  |  |
| **HEALTH RECORDS (HARD COPY)** | IS COST ANALYSIS REQUIRED | |  |  |
| **MEDICINE (EMG, RADIOLOGY, BACLOFEN CLINIC, LIBRARY)** | IS COST ANALYSIS REQUIRED | |  |  |
| **NURSING** | IS COST ANALYSIS REQUIRED | |  |  |
| **NUTRITION & FOOD SERVICES** | IS COST ANALYSIS REQUIRED | |  |  |
| **OCCUPATIONAL THERAPY** | IS COST ANALYSIS REQUIRED | |  |  |
| **PHYSIOTHERAPY** | IS COST ANALYSIS REQUIRED | |  |  |
| **PHARMACY** | IS COST ANALYSIS REQUIRED | |  |  |
| **PSYCHOLOGY** | IS COST ANALYSIS REQUIRED | |  |  |
| **RECREATION THERAPY** | IS COST ANALYSIS REQUIRED | |  |  |
| **SEXUAL HEALTH** | IS COST ANALYSIS REQUIRED | |  |  |
| **SOCIAL WORK** | IS COST ANALYSIS REQUIRED | |  |  |
| **SPEECH-LANGUAGE PATHOLOGY** | IS COST ANALYSIS REQUIRED | |  |  |
| **VOCATIONAL REHAB SERVICE** | IS COST ANALYSIS REQUIRED | |  |  |
| **OTHER RESOURCES: (SPECIFY)** | IS COST ANALYSIS REQUIRED | |  |  |
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| **Community of Care *Signature Sheet*** | | | VCH – VANCOUVER COMMUNITY | | | | |
| *SIGNATURE OF APPROVAL IS REQUIRED FROM THE RELEVANT MEDICAL/PROGRAM DIRECTOR OR MANAGER.*  For Vancouver Community approvals, contact Krisztina Vasarhelyi at [krisztina.vasarhelyi@vch.ca](mailto:krisztina.vasarhelyi@vch.ca) and for projects involving Long-Term Care (LTC), please contact Monica Lee at [monica.lee1@vch.ca](mailto:monica.lee1@vch.ca). | | | | | | | |
| **Research Project Information** | | | | | | | |
| **RESEARCH STUDY TITLE** |  | | | | | | |
| **REB #** |  | | | **DATE** |  | | |
| **PRINCIPAL INVESTIGATOR** |  | | |  |  | | |
| **PRIMARY CONTACT** |  | | |  |  | | |
| **VANCOUVER COMMUNITY SITE** | **COST ANALYSIS REQUIRED** | **SITE MANAGER** | | **SITE DIRECTOR** | | **SIGNATURE** |
| NAME OF SITE | IS COST ANALYSIS REQUIRED |  | |  | |  |
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| NAME OF SITE | IS COST ANALYSIS REQUIRED |  | |  | |  |
| NAME OF SITE | IS COST ANALYSIS REQUIRED |  | |  | |  |
| **VCH DATABASE:**  **(SPECIFY)** | IS COST ANALYSIS REQUIRED |  | |  | |  |
| **OTHER DATABASE: (SPECIFY)** | IS COST ANALYSIS REQUIRED |  | |  | |  |
| **CLINICAL UNIT: (SPECIFY 1-3)** | IS COST ANALYSIS REQUIRED |  | |  | |  |
| **OTHER RESOURCE: (SPECIFY)** | IS COST ANALYSIS REQUIRED |  | |  | |  |
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| **Community of Care *Signature Sheet*** | | VCH – COASTAL  (includes Bella Coola General Hospital, Lions Gate Hospital, Pemberton Health Centre, qathet General Hospital, Heiltsuk Hospital, Sechelt Hospital, Squamish General Hospital, and Whistler Health Care Centre) | | | | |
| *SIGNATURE OF APPROVAL IS REQUIRED FROM THE RELEVANT MEDICAL/PROGRAM DIRECTOR OR MANAGER.*  Please specify the hospital name that will be utilized. If multiple coastal hospital will be used, please use the ‘Other resources: Specify’. For example: ‘Other resources: Pharmacy’ – ‘Hospital: Sechelt hospital’ | | | | | | |
| **Research Project Information** | | | | | | |
| **RESEARCH STUDY TITLE** |  | | | | | |
| **REB #** |  | | | **DATE** | |  |
| **PRINCIPAL INVESTIGATOR** |  | | |  | |  |
| **PRIMARY CONTACT** |  | | |  | |  |
| **VCH DEPARTMENT** | **HOSPITAL** | **COST ANALYSIS REQUIRED** | **VCH SIGNATORY NAME** | | **SIGNATURE** | |
| **PHARMACY** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **RADIOLOGY** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **CLINICAL CHEMISTRY** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **MICROBIOLOGY** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **OPERATING ROOM** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **ANESTHESIA** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **ANATOMICAL PATHOLOGY** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **HEMATOPATHOLOGY** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **DATA & ANALYTICS** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **HEALTH RECORDS (HARD COPY)** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **VCH DATABASE:**  **(SPECIFY)** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **OTHER DATABASE: (SPECIFY)** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **CLINICAL UNIT: (SPECIFY 1-3)** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **1) CLINICAL UNIT** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **2) CLINICAL UNIT** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **3) CLINICAL UNIT** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **OTHER RESOURCES: (SPECIFY)** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
| **OTHER RESOURCES: (SPECIFY)** | NAME OF HOSPITAL SITE | IS COST ANALYSIS REQUIRED |  | |  | |
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| **Community of Care *Signature Sheet*** | | | VCH – COASTAL COMMUNITY | | |
| *SIGNATURE OF APPROVAL IS REQUIRED FROM THE RELEVANT MEDICAL/PROGRAM DIRECTOR OR MANAGER.* | | | | | |
| **Research Project Information** | | | | | |
| **RESEARCH STUDY TITLE** |  | | | | |
| **REB #** |  | | | **DATE** |  |
| **PRINCIPAL INVESTIGATOR** |  | | |  |  |
| **PRIMARY CONTACT** |  | | |  |  |
| **COASTAL COMMUNITY SITE OR PROGRAM** | **COST ANALYSIS REQUIRED** | **NAME OF VCH SIGNATORY** | | | **SIGNATURE** |
| NAME OF SITE | IS COST ANALYSIS REQUIRED |  | | |  |
| NAME OF SITE | IS COST ANALYSIS REQUIRED |  | | |  |
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| **VCH DATABASE:**  **(SPECIFY)** | IS COST ANALYSIS REQUIRED |  | | |  |
| **OTHER DATABASE: (SPECIFY)** | IS COST ANALYSIS REQUIRED |  | | |  |
| **CLINICAL UNIT: (SPECIFY)** | IS COST ANALYSIS REQUIRED |  | | |  |
| **OTHER RESOURCE: (SPECIFY)** | IS COST ANALYSIS REQUIRED |  | | |  |
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| **Community of Care *Signature Sheet*** | | | VCH - RICHMOND | | | | |
| *SIGNATURE OF APPROVAL IS REQUIRED FROM THE RELEVANT MEDICAL/PROGRAM DIRECTOR OR MANAGER.*  Please complete the VCHRI Research Impact Analysis Form for each Richmond department/clinic a research project will impact. This is a VCH-Richmond specific requirement. | | | | | | | |
| **Research Project Information** | | | | | | | |
| **RESEARCH STUDY TITLE** |  | | | | | | |
| **REB #** |  | | | **DATE** | |  | |
| **PRINCIPAL INVESTIGATOR** |  | | |  | |  | |
| **PRIMARY CONTACT** |  | | |  | |  | |
| **VCH DEPARTMENT** | **COST ANALYSIS REQUIRED** | **DEPARTMENT HEAD** | | **PROGRAM MANAGER** | **SIGNATURE** | |
| **ACUTE CARE (SPECIFY DEPARTMENT)** | IS COST ANALYSIS REQUIRED |  | |  |  | |
| **COMMUNITY CARE (SPECIFY DEPARTMENT)** | IS COST ANALYSIS REQUIRED |  | |  |  | |
| **PRIMARY CARE (SPECIFY DEPARTMENT)** | IS COST ANALYSIS REQUIRED |  | |  |  | |
| **HEALTH RECORDS (HARD COPY)** | IS COST ANALYSIS REQUIRED |  | |  |  | |
| **DATA & ANALYTICS** | IS COST ANALYSIS REQUIRED |  | |  |  | |
| **VCH DATABASE (E.G. PARIS, ORMIS)** | IS COST ANALYSIS REQUIRED |  | |  |  | |
| **OTHER DATABASE (SPECIFY)** | IS COST ANALYSIS REQUIRED |  | |  |  | |
| **OTHER RESOURCES (SPECIFY)** | IS COST ANALYSIS REQUIRED |  | |  |  | |
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| **Community of Care *Signature Sheet*** | | | | VCH – CORPORATE/REGIONAL | | |
| *SIGNATURE OF APPROVAL ARE REQUIRED FROM THE RELEVANT MEDICAL/PROGRAM DIRECTOR OR MANAGER.* | | | | | | |
| **Research Project Information** | | | | | | |
| **RESEARCH STUDY TITLE** |  | | | | | |
| **REB #** |  | | | | **DATE** |  |
| **PRINCIPAL INVESTIGATOR** |  | | | |  |  |
| **PRIMARY CONTACT** |  | | | |  |  |
| **CORPORATE SITE OR DEPARTMENT** | | **COST ANALYSIS REQUIRED** | **NAME OF VCH SIGNATORY** | | | **SIGNATURE** |
| NAME OF SITE | | IS COST ANALYSIS REQUIRED |  | | |  |
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