# Study Application Form

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| 1. **Study name** | | | **Study No.:** |
| **GEM project** | | |  |
| **2. Contact details** | | | |
|  | **Principal Investigator** | **Main** | |
| **Name** | Dr Miles Parkes (Chief Investigator) | **Merry Jay Jimenez-Smith** | |
| **Phone** | 01223 216389 | 01223 596461 | |
| **Email** | miles.parkes@addenbrookes.nhs.uk | merry.jimenez@addenbrookes.nhs.uk | |
| **Address** | Cambridge University Hospitals NHS Foundation Trust  Box 201A, Dept of Gastroenterology,  Addenbrooke’s Hospital,  Cambridge. |  | |
| **3. PI’s research interests** | | | |
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| **4. Study type** | | | | | | | | | | | | |
| *Please define the type of study this will be* | | | | | | | | | | | | |
| **Recall of volunteers** | |  | | | **Pre-existing NBR data only** | | |  | | | | |
| **Total number requested:** | |  | | | **Data requested on X volunteers:** | | |  | | | | |
| **5. Recall by genotype** *(if applicable)* | | | | | | | | | | | | |
| *Please provide specific information relevant to your preferred genotypic recall method below* | | | | | | | | | | | | |
| **SNP** | | | | | | | | | | | | |
| **rs number** | **Major homozygotes** | | | | | **Minor homozygotes** | | | **Heterozygotes** | | | **Chromosomal position** |
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| **SNV** | | | | | | | | | | | | |
| **rs number (if available)** | | | **Insertion** | | | | **Deletion** | | | | **Chromosomal position** | |
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| **Haplotype** | | | | | | | | | | | | |
| **Gene/Haplotype name** | | | | **Chromosomal range** | | | | | | **Alleles (imputation may be used)** | | |
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| **CNV** | | | | | | | | | | | | |
| **Chromosomal range** | | | | | | |  | | | | | |
| **Recall by other** *(i.e. phenotype)* *Please provide details* | | | | | | | | | | | | |
| **Please state details regarding how volunteers will be grouped for recall**  *This describes the different groups of genotypes needed in your experiments, these should be compiled from the above information, please provide as much detail as possible.* | | | | | | | | | | | | |
| **Frequency of group(s) in normal population and study population:** | | | | | | | | | | | | |
| **Groups to be matched? Yes  No** | | | | | | | | | | | | |
| If yes:  **By genotypic sex** | **By age (< 5yrs)** | | | | | **By age (5 – 10yrs)** | | | **Other**  (please provide details) | | | **Ethnicity** |

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| **6. Current knowledge** |
| *Please detail the current knowledge regarding the functional significance of the marker(s) of interest and their likely associations with disease including risk estimates or absolute risks.* |

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| **7. Study summary** |
| *Please provide an overview of the proposed study including the commitment required by each study participant (1 A4 side maximum).* |

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| **8. Scientific justification** |
| *Please give the scientific justification for the proposed study, including relevant statistical support and previous results (2 A4 sides maximum).* |

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| **9. Data required *(pre-existing)*** | |
| *Please detail the pre-existing NBR data that you require (if applicable)* | |
| **10. Volunteer recall** | |
| **Total blood volume required per volunteer: ml**  *Please give details for each visit* | |
| *If >50ml per volunteer is required please provide clear justification for the amount requested* | |
| *Please detail any other clinical interventions required (e.g blood pressure, height, weight).* | |
| **Will volunteer participation be conducted at one of our local BioResource? Yes  No**  *If ‘no’ please provide further details on where study participation will take place*  WHICH ONES if known? | |
| **Please indicate possible options for days and times of volunteer participation** | |
| **Days** | **Times** |
| Monday | Before 09:00 |
| Tuesday | 09:00 – 13:00 |
| Wednesday | 13:00 – 17:00 |
| Thursday | Other time requirements: |
| Friday | **Can samples be received on consecutive days?** Y/N |
| **Maximum number of samples/day:** | **Maximum number of samples/week:** |
| **Please indicate any other limitations** | |
| **Please outline any payments volunteers will receive and when these will be made** | |
| **Researchers are responsible for all study travel expenses. We expect that you offer to**  **reimburse expenses for all volunteers in addition to any payment they receive.** | |

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| **11. Previous studies** |
| *If the any of the NIHR BioResource has previously supported any of your studies, please detail the name, study number and any applicable results* |
| **12. Study timeline** |
| *Please provide details of the anticipated timeline with potential study start & end dates* |
| **13. Ethics** |
| **Is there currently ethical approval in place for this study? Yes  No**  *If ‘yes’ please attach copies of your Protocol, Patient Information Leaflet, Consent Form and letter of favourable opinion to this application* |
| **14. Signature of Principle Investigator** |
| *Please send us this form electronically as a Word document*  Print name:  Signature (optional):  Date: |
| **15. National BioResource Decision** |
| *To be filled in by the National BioResource team*    This application has been APPROVED  DECLINED  by SAB  INTERNAL REVIEW  (*state names of internal reviewers*)  Date: |