# 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** |
|  |[ ] [ ] [ ]   |
|  |[ ] [ ] [ ]   |
|  |[ ] [ ] [ ]   |
|  |[ ] [ ] [ ]   |
|  |[ ] [ ] [ ]   |
| **SNV** [ ]  |
| **rs number (if available)** | **Insertion** | **Deletion** | **Chromosomal position** |
|  |[ ] [ ]   |
|  |[ ] [ ]   |
|  |[ ] [ ]   |
|  |[ ] [ ]   |
| **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:  |