BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

WOMEN'S HEALTH RESEARCH INSTITUTE AT BC WOMEN'S

PROGRAM UTILIZATION FORM

This Form must be completed if your research study impacts a BC Women's Hospital + Health Centre (BCWH) program or clinic. Refer to the *BCWH Program Utilization Form Guidance Notes* for information on institutional approval, program utilization, and the submission process. Note that this process generally takes at least 6-8 weeks.

The Programs/Clinics are responsible for determining if these services will have sufficient impact as to require cost recovery. It is the responsibility of the Principal Investigator/Project Lead to ensure proper consultation is done with the Programs/Clinics prior to finalizing the project budget.

Principal Investigator/Project Site Lead Declaration

It is the responsibility of the Principal Investigator (PI)/Project Site Lead to inform the program/clinic and the Women's Health Research Institute (whri_cwbc@cw.bc.ca) in a timely manner (within 4 weeks) if there will be any potential or has been an actual change in the PI and/or Site Lead's **BC Women's Hospital medical staff privileges or appointment** during the study period, as this may impact the ability of the study to proceed.

If a change in privileges or appointment may occur or has occurred, study approval will be re-reviewed by the program/clinic and by the Women's Health Research Institute.

Please select the declaration option below that best fits with the current research study:

☐ The Principal Investigator overseeing the study holds an appointment with the Children's & Women's Health Centre of British Columbia.

As Principal Investigator, I understand it is my responsibility and agree to inform the program/clinic and the WHRI within 4 weeks of any potential or actual change in my BC Women's Hospital + Health Centre medical staff privileges or appointment during the study period.

Principal Investigator Signature: _____

Print Name _____

Date _____

☐ The Principal Investigator has designated a Project Site Lead to oversee study activities who holds an appointment with the Children's & Women's Health Centre of British Columbia.

As designated Project Site Lead, I understand it is my responsibility and agree to inform the program/clinic and the WHRI within 4 weeks of any potential or actual change in my BC Women's Hospital + Health Centre medical staff privileges or appointment during the study period.

Project Site Lead Signature: _____

Print Name _____

Date _____

Section 1: Project Information

Study Title:	
REB#:	REB Approval Date: Date ☐ In progress
Principal Investigator Name:	PI Email:
Primary Contact Name:	Primary Contact Email:
Primary Contact Role: (E.g., Researcher, learner-student, resident)	Study Sponsor (if applicable):
Anticipated start date (in program): Date	Anticipated end date (in program): Date
Summarize the research proposal, including study purpose, study population, and research method (please be brief and use lay language):	

Section 2: Supporting Documents

Include the following documents (if applicable) with your PU Form before the signatories can review your request:

- ☐ Study/Project Protocol
- ☐ RISe (Research Ethics) Application
- ☐ Research Ethics Approval Certificate
- ☐ Consent Form(s)/ Waiver of consent
- ☐ Patient Information Sheet
- ☐ Recruitment Material (e.g., posters)
- ☐ Service agreements (e.g., lab services, imaging, pharmaceutical)

Section 3: BC Women's Hospital Program and/or Specific Clinic

One form must be submitted for each program that is impacted by your study.

<table>
<tr><th colspan="2">ACUTE PROGRAMS</th></tr>
<tr><td>☐ Maternal Newborn Program:
☐ Antepartum/Postpartum
Specify Unit(s): _____
(Evergreen, Dogwood, Arbutus, Balsam)
☐ Cedar Birthing Suites
☐ Teck L&D, OB Surgical Services, UCC
Specify Area(s): _____
☐ Perinatal Substance Use (FIR Unit)</td><td>☐ Neonatal Program:
☐ NICU
☐ Neonatal Follow-up
☐ MBC</td></tr>
<tr><th colspan="2">AMBULATORY PROGRAMS</th></tr>
<tr><td>☐ Maternity Ambulatory Program
Specify Clinic(s): _____
(I.e., Anesthesia, Antepartum Homecare, Diabetes in Pregnancy, Fetal Assessment, Fetal, Diagnosis Service, Hematology, Infectious Diseases, Internal Medicine, Iron Infusions, Lactation Consultation, Maternal Fetal Medicine, New Beginnings Maternity, Prenatal/Special Procedures, Social Work, Ultrasound).</td><td>☐ Nurse Practitioner Services
Specify Clinic(s): _____
(I.e., After Breast Cancer, Aboriginal Mother's Centre (AMC), Vancouver Women's Health Collective (VWHC), WISH drop-in Centre, Sisterspace Overdose Prevention Site (OPS), Heart Health, Newcomer Services).</td></tr>
<tr><td>☐ Gynecology and Sexual Health Program
Specify Clinic(s): _____
(I.e., Chronic Pelvic Pain and Endometriosis, Early Pregnancy Assessment Clinic (EPAC), Recurrent Pregnancy Loss (RPL), ACCESS, Continence, CARE Program)</td><td>☐ Gynecology Daycare Surgical Services</td></tr>
<tr><td>☐ Breast Health Program</td><td>☐ Oak Tree Clinic</td></tr>
<tr><td>☐ Sexual Assault Service</td><td>☐ Provincial Medical Genetics Program</td></tr>
<tr><td>☐ Complex Chronic Diseases Program</td><td>☐ Penicillin Allergy Clinic</td></tr>
<tr><td colspan="2">☐ Other, please specify: _____</td></tr>
<tr><td colspan="2">For a full list of BCWH Services: http://www.bcwomens.ca/our-services</td></tr>
</table>

Section 4 PROGRAM UTILIZATION REQUEST

a) What BCWH Program/Clinic resource(s) are you requesting? Check all that apply.	☐ Staff (e.g. booking clerk, nurse, health records tech) ☐ Infrastructure (e.g., Exam Room, Equipment) ☐ Clinic or Program Records ☐ Parent Advisors (NICU) ☐ Other, please list: _____ ☐ None
b) What tasks are being requested of Hospital Staff for this study?	☐ Introduce research study/staff to patient ☐ Chart flagging ☐ Chart access ☐ Data entry ☐ Sample collection ☐ Other ☐ None
c) How many research participants will be participating at BCWH (in this program specifically)?	
d) Describe what is being requested **of Program Staff and/or Program resources** for this study. For Acute programs, if more than one clinic area was selected in Section 3, list requests for each area separately. For Ambulatory programs, where applicable, include the following: - Type of resource - Duration (i.e. minutes/hours) - Time (of day) - Frequency (weekly, ad hoc) - Start Date - End Date	
e) Describe study activities conducted in the Program by **non-Program Staff.** *e.g., Research staff, trainees, research nurse*	
f) If your study requires participant recruitment within a program, how will your study representative be introduced to the patient or family member?	
g) How will program staff be oriented to the study (or trained) if necessary?	

h) How will the research results be shared with the program?	
i) If required by the program, is funding available to support any requested BCWH Program/Clinic resources?	☐ Yes ☐ No
j) Please include any additional information about your study that would help during our review.	
k) Would you like to promote your study on the BC Women's Hospital website?	☐ Yes ☐ No

Please see next page for required signatures:

For Acute Programs, please see Section **5.1**

For Ambulatory Programs, please see Section **5.2.A**; for Provincial Medical Genetics Program see Section **5.2.B**

To obtain signatures, please submit your PU Form request to:

Acute: Maternal Newborn Programs

- Interim: Submit completed form and supporting documentation to **Travis Boulter** (travis.boulter@phsa.ca) who will assist with obtaining all necessary signatures.

Acute: Neonatal Programs

- Step 1: Contact **Lindsay Richter** (lindsay.richter@cw.bc.ca) prior to submission of the PU Form to schedule a presentation at the NICU Research and Quality rounds.
- Step 2: Submit the completed form and supporting documentation to Lindsay who will assist with obtaining all necessary signatures.

Ambulatory Programs (including the Provincial Medical Genetics Program)

- Submit completed form and supporting documentation to **Carola Muñoz** (carola.munoz@cw.bc.ca) who will assist with obtaining all necessary signatures.

Section 5.1: Required Signatures (ACUTE PROGRAMS)

Program Manager Signature
Add handwritten, scanned signature, or signature line in box below:

Print Name
Date

Program Medical Lead Signature
Add handwritten, scanned signature or signature line in box below:

Print Name
Date

Senior Director
Add handwritten, scanned signature or signature line in box below:

Print Name
Date

Senior Medical Director
Add handwritten, scanned signature or signature line in box below:

Print Name
Date

**Once Senior Director/Senior Medical Director signature is obtained, please submit to the office of the WHRI Executive Director (Rm H214 c/o Lori Brotto)*

Executive Director, Women's Health Research Institute Signature
Add handwritten, scanned signature or signature line in box below:

Print Name
Date

For program use only. Notes/ Comments/Additional Information Required:

Section 5.2.A: Required Signatures (AMBULATORY PROGRAMS)

Program Manager Signature
Add handwritten, scanned signature, or signature line in box below:

Print Name
Date

Program Medical Lead Signature
Add handwritten, scanned signature or signature line in box below:

Print Name
Date

Senior Patient Services Director
Add handwritten, scanned signature or signature line in box below:

Print Name
Date

Senior Medical Director
Add handwritten, scanned signature or signature line in box below:

Print Name
Date

**Once Senior Director/Senior Medical Director signature is obtained, please submit to the office of the WHRI Executive Director (Rm H214 c/o Lori Brotto)*

Executive Director, Women's Health Research Institute Signature
Add handwritten, scanned signature, or signature line in box below:

Print Name
Date

Section 5.2.B: Required Signatures (Provincial Medical Genetics Program)

Program Operations Director Signature
Add handwritten, scanned signature, or signature line in box below:

Print Name _____
Date _____

Program Medical Director Signature
Add handwritten, scanned signature or signature line in box below:

Print Name _____
Date _____

Senior Medical Director
Add handwritten, scanned signature or signature line in box below:

Print Name _____
Date _____

Chief Operating Officer, BC Women's Hospital + Health Centre
Add handwritten, scanned signature or signature line in box below:

Print Name _____
Date _____

**Once Senior Director/Senior Medical Director signature is obtained, please submit to the office of the WHRI Executive Director (Rm H214 c/o Lori Brotto)*

Executive Director, Women's Health Research Institute Signature
Add handwritten, scanned signature, or signature line in box below:

Print Name _____
Date _____

For program use only. Notes/ Comments/Additional Information Required: