Humber River Health

RESEARCH IMPACT ASSESSMENT (RIA) FORM

Research Impact Assessment (RIA) applies to any research conducted at Humber River Health (HRH) and/or performed (or supervised) by HRH staff, including student projects. The RIA will identify any impacts to resources, data, programs and/or services required at HRH.

Principal Investigator (PI) (or Delegate) is responsible for informing stakeholders impacted by the research **before submitting to the HRH REB (or CTO Qualified Board)**. Where applicable, all issues must be resolved prior to finalization of site budget negotiations.

INSTRUCTIONS

- Please open this document in **Adobe Acrobat**.
- **All sections** of the RIA Form **MUST** be completed. Where not applicable, please put N/A.
- Please **submit typed, signed, and/or scanned RIA Form and accompanying documents** to research@hrh.ca.
- Accompanying documents to include: 1) Protocol (mandatory), 2) Informed Consent Form, 3) Site Budget, and 4) Agreement(s).

Full Study Title:		
Sponsor Protocol Number: ☐ Not applicable		
Sponsor: ☐ Not applicable		
Principal Investigator (PI):	**Name**:	**Institution**:
Site PI at HRH: (must be HRH Staff or Physician)	**Name**:	**Department**:
Co-Investigator(s):	**Name(s):**	**Institution, Department:**
Study Coordinator/ Contact Person for this RIA Form (if not the Site PI)	**Name**:	**Institution, Department**:

A. GENERAL INFORMATION

Brief Description:

If applicable, include Study Schema as an image below.

Primary Objective:

Will this study be:

☐ **Single-centered** ➢ **Estimated TOTAL number of participants to be enrolled:** _____

☐ **Multi-centered** ➢ **Role of HRH:** ☐ **Lead Site** ☐ **Recruiting Site** ☐ **Other:** _____

Will this study be:

☐ **Retrospective** ➢ **Estimated sample size at HRH**: _____

☐ **Prospective**

↳ ➢ **Estimated TOTAL number of participants to be enrolled at HRH**: _____

➢ **Estimated MONTHLY number of participants to be enrolled at HRH**: _____

Site*: ☐ **Wilson** ☐ **Church RCC** ☐ **Church - Dialysis** ☐ **Finch RCC**

**Where research will take place*

Will any research activity take place outside of HRH, e.g., in physician's private practice?

☐ **Yes** ➢ **Please specify**:

☐ **No**

Will there be Homecare involvement?

☐ **Yes ➢ Please specify**:

☐ **No**

Plan to submit to the following REB of Record for HRH:

☐ **Humber River Health REB (HRH REB)**

☐ **CTO Qualified Board**

B. FUNDING

(For an industry-funded study, 30% overhead applies & HRH REB service fee)

Is the study funded?	☐ **Yes ➢** ***Complete below and note HRH REB service fees may apply*** ☐ **No**
Source of Funding:	
Total funds awarded:	
Total funds to HRH:	

C. PHARMACY

Is HRH Pharmacy involved?

☐ **Yes ➢** ***Complete the table below and the Research Pharmacy Accountability document***

☐ **No ➢ Please specify why:**

Study Drug(s): **(list all required by the study)**	
Who will administer Study Drug(s)?	
Where will Study Drug(s) be administered?	
Where will Study Drug(s) be stored?	

D. HRH LABORATORY

Blood drawn by HRH Ambulatory Clinic Staff	☐ **Yes** ☐ **No**

Blood drawn by HRH Outpatient Staff	☐ **Yes ➢ Please specify who/where**: ☐ **No**
Blood drawn by HRH Inpatient Staff	☐ **Yes ➢ Please specify who/where**: ☐ **No**
Specimen(s) sent to Central Lab	☐ **Yes** ☐ **No**
Specimen(s) to be processed, packaged and shipped out by:	
HRH Local Labs Involved ☐ **Yes ➢ Identify each lab test required as per Protocol**: ☐ **No**	

E. HRH MEDICAL IMAGING (MI)

Medical Imaging	☐ **Yes** ☐ **No**	**Impact**:
Nuclear Medicine Imaging	☐ **Yes** ☐ **No**	**Impact**:
Image transfer required?	☐ **Yes** ☐ **No**	**Explain**:

F. HRH PATHOLOGY

Will there be any use of human tissue?	☐ **Yes** ☐ **No**	**List all testing required for each specimen**:
Special handling required?	☐ **Yes** ☐ **No**	**Explain**:

G. CLINICAL AREAS

Surgical Services	☐ **Yes** ☐ **No**	**Pre-op impact**: **Post-op impact**:

Cardiology	☐ **Yes** ☐ **No**	**Impact**:
Critical Care	☐ **Yes** ☐ **No**	**Impact**:
Emergency Department	☐ **Yes** ☐ **No**	**Impact**:
Endoscopy	☐ **Yes** ☐ **No**	**Impact**:
Maternal & Child	☐ **Yes** ☐ **No**	**Impact**:
Mental Health & Addictions	☐ **Yes** ☐ **No**	**Impact**:
Nephrology	☐ **Yes** ☐ **No**	**Impact**:
Oncology	☐ **Yes** ☐ **No**	**Impact**:
Seniors Care	☐ **Yes** ☐ **No**	**Impact**:
Other (specify):	☐ **Yes** ☐ **No**	**Impact**:

H. HEALTH INFORMATION SYSTEMS

Review of HRH Charts by External Research Staff	☐ **Yes** ☐ **No**	**Impact**:
Other (specify):	☐ **Yes** ☐ **No**	**Impact**:

I. FOCUS ON TECHNOLOGY

HRH Command Centre	☐ **Yes** ☐ **No**	**Impact**:
A New Medical Device	☐ **Yes** ☐ **No**	**Impact**:
A New Analytic Tool	☐ **Yes** ☐ **No**	**Impact**:
Other (specify):	☐ **Yes** ☐ **No**	**Impact**:

J. RESEARCH STAFFING

Study Coordinator (SC)	☐ **Study will require SC services from HRH Clinical Research Office** ☐ **Study will require SC services from HRH Research Institute** ☐ **Study will require SC from outside HRH** Unpaid Research Person must be registered with the Clinical Research Office to ensure liability coverage, privacy and confidentiality training, etc. ☐ **Site PI will hire own SC at HRH** ☐ **Other (specify):**	**Please provide SC name and details**:

Where will the SC conduct the Study?	☐ **On-site at HRH ➢ Office room number:** ☐ **Off-site ➢ Please specify where**:
Other staff required? **(e.g., Statistician etc.)**	☐ **Statistician** ☐ **Transcriptionist** ☐ **Other ➢ Please specify**: ☐ **Not Applicable**

K. CONTRACTS / AGREEMENTS

Will the Study involve contracts or agreements?	☐ **Clinical Trial/Study Agreement (CTA/CSA)** ☐ **Material Transfer Agreement (MTA)** ☐ **Data Transfer/Sharing Agreement (DTA/DSA)** ☐ **Financial Agreement** ☐ **Other ➢ Please specify**: ☐ **Not Applicable**

L. SIGNATURE PAGE

Email the completed RIA Form to impacted Program & Physician Directors and request approval with two-week deadline. Approval may be obtained by either 1) Email (attach attestation), or 2) Signature.

Department	**Program Director** (person with budget responsibility)	**Physician Director**
	Name: Signature: Date:	Name: Signature: Date:
	Name: Signature: Date:	Name: Signature: Date:
	Name: Signature: Date:	Name: Signature: Date:
	Name: Signature: Date:	Name: Signature: Date:
	Name: Signature: Date:	Name: Signature: Date: