1. **Indicate the sites[[1]](#footnote-1) from which research participants will be recruited:**

|  |  |  |
| --- | --- | --- |
| **Site** | **Department** | **Number of Participants** |
| [ ] Footscray Hospital | Enter Department Name | Enter Number |
| [ ]  Sunshine Hospital  | Enter Department Name | Enter Number |
| [ ]  Williamstown Hospital  | Enter Department Name | Enter Number |
| [ ]  Sunbury Day Hospital | Enter Department Name | Enter Number |
| [ ]  Drug and Alcohol Services | Enter Department Name | Enter Number |
| [ ]  Hazeldean Transition Care | Enter Department Name | Enter Number |
| [ ]  Reg Geary House | Enter Department Name | Enter Number |
| [ ]  Bacchus Marsh and Melton Regional Hospital | Enter Department Name | Enter Number |
| [ ]  Melton Health & Community Services | Enter Department Name | Enter Number |
| [ ]  Bacchus Marsh Community Health Centre | Enter Department Name | Enter Number |
| [ ]  Melton Health | Enter Department Name | Enter Number |
| [ ]  Grant Lodge Residential Aged Care | Enter Department Name | Enter Number |

1. **Hospital/network services required for this research project:**

Indicate (please tick) which hospital services will be required (**including host department**) to undertake this research:

|  |  |
| --- | --- |
| **Emergency, Medicine and Cancer Services** | **Perioperative and Critical Care Services** |
| [ ]  Acute Ambulatory Care | [ ]  Anaesthetics and Pain Management |
| [ ]  Addiction Medicine | [ ]  Cardiology |
| [ ]  Dermatology | [ ]  Central Sterilising Services |
| [ ]  Endocrinology & Diabetes | [ ]  Elective Booking Service |
| [ ]  Emergency Medicine | [ ]  Facio-Maxillary Surgery |
| [ ]  Gastroenterology | [ ]  General and Breast Surgery |
| [ ]  General Medicine | [ ]  General and Colorectal Surgery |
| [ ]  Haematology | [ ]  General and Endocrine Surgery |
| [ ]  Hospital In The Home | [ ]  General and Upper Gastrointestinal Surgery |
| [ ]  Immunology | [ ]  Intensive Care Services |
| [ ]  Infectious Diseases | [ ]  Neurosurgery |
| [ ]  Medical Oncology | [ ]  Ophthalmology |
| [ ]  Medical Staff | [ ]  Orthopaedic Surgery |
| [ ]  Nephrology | [ ]  Otolaryngology, Head, Neck Surgery |
| [ ]  Neurology | [ ]  Paediatric Surgery |
| [ ]  Renal Dialysis | [ ]  Plastic, Reconstructive and Facio Maxillary Surgery |
| [ ]  Respiratory and Sleep Disorders | [ ]  Thoracic Surgery |
| [ ]  Rheumatology | [ ]  Urology Surgery |
| [ ]  Palliative Care | [ ]  Vascular Surgery |
| [ ]  Stroke Service | **Subacute & Aged Care Services** |
| **Clinical Support and Specialist Clinic Services** | [ ]  Acute Aged Care |
| [ ]  Bone Density Unit | [ ]  Cardio-geriatric Service |
| [ ]  Health Information Services/Medical Records | [ ]  Dementia Management Unit |
| [ ]  Interventional Radiology | [ ]  Geriatric Evaluation and Management |
| [ ]  Medicine Imaging | [ ]  Inpatient Rehabilitation |
| [ ]  Nursing Services | [ ]  Transition Care Program |
| [ ]  Pathology | [ ]  Ortho-Geriatric Service |
| [ ]  Performance Unit | [ ]  Palliative Care (Inpatient) |
| [ ]  Pharmacy | [ ]  Subacute and Non acute Access and Pathways  |
| [ ]  Specialist Clinics (Adult) | [ ]  Wellcare Program |
| **Allied Health** | **Women’s and Children’s Services** |
| [ ]  Audiology | [ ]  Gynaecology |
| [ ]  Exercise Physiology | [ ]  Obstetric Services |
| [ ]  Language Services | [ ]  Maternal Fetal Medicine |
| [ ]  Neuropsychology | [ ]  Special Care Nursery |
| [ ]  Nutrition and Dietetics | [ ]  Paediatric Medicine |
| [ ]  Occupational Therapy | **Drug Health Services** |
| [ ]  Pastoral Care | [ ]  Adolescent Community Programs |
| [ ]  Physiotherapy | [ ]  Adult Specialist Services |
| [ ]  Podiatry | [ ]  Community Residential Drug Withdrawal Units |
| [ ]  Psychology | [ ]  Dual Diagnosis Residential Rehabilitation Centre |
| [ ]  Social Work | [ ]  Nurse Practitioner Clinics |
| [ ]  Speech Pathology | [ ]  Psychology Clinics |
| **Community Services** | [ ]  Women’s Therapeutic Day Rehabilitation Program |
| Aboriginal Health, Policy & Planning | **Other** |
| ACE (Advice, Coordination and Expertise) | [ ]  Enter text |
| Aged Care Assessment Service | [ ]  Enter text |
| Central Access Unit (CAU) | [ ]  Enter text |
| Children’s Allied Health Service | [ ]  Enter text |
| Community Based Rehabilitation | [ ]  Enter text |
| Community Transition Care Program | [ ]  Enter text |
| Falls & Fracture Clinic | [ ]  Enter text |
| GP Integration Unit | [ ]  Enter text |
| Health Independence Programs Community Services | [ ]  Enter text |
| Hospital Admission Risk Program | [ ]  Enter text |
| Subacute Ambulatory Care Services | [ ]  Enter text |

1. **Statement of Approval forms**
* For each department ticked above, a separate Statement of Approval Form must be completed for every Service/Host Department involved in this research project. The Service Department Head and the Principal Researcher must sign each form.
* Requirements for research projects should be discussed with service/department heads as required. Researchers must provide a copy of each signed and completed form to the relevant service/department for their records.
* The above requirements also apply to research projects that are engaging Service Departments for procedures considered “Standard of Care”.
* Medical Records/Health Info Services (HIS); Statement of Approval Form for HIS is only required if Physical Records are being retrieved. If researchers are collecting information from BOSSNET (electronic records) only, then a Statement of Approval is not required except when researchers are collecting patient data prior to 24 November 2011
* Medical Imaging & Pathology; please review additional information and requirements on the website as they require separate forms.

**STATEMENT OF APPROVAL FORM**

*If the project is to be undertaken in the same department at more than one site, complete a separate form for relevant departments at each site.*

|  |  |
| --- | --- |
| **Service Department:** | Insert Service Department name |
| **Project No:** | Insert ID reference | **Expected Commencement Date:** | Select date |

**Title of project:**

|  |
| --- |
| Insert Project Title |
| **P****rincipal Researcher:** | Insert PI Name |

I have discussed this study with the Principal Researcher having seen the application and protocol and I am:

|  |
| --- |
|[ ]  Able to do the investigations indicated with the present resources of the Insert Service Department name \* Department and/or support the conduct of this project. |
|[ ]  Unable to do the investigations within the present resources of the Department but would be willing to undertake them with financial assistance for: [ ] Staff [ ] Equipment  [ ] Maintenance [ ] Other (Please specify below) |

Comment (Please specify nature of assistance and estimated costs):

|  |
| --- |
| Enter text |
| Service Department Cost Centre to be Credited: | Enter cost centre code |
| Charges - select one option only | 1. [ ] Charge to Western Health cost centre Enter code *or*
2. [ ] Provide Billing details below

Contact name: Enter textCompany name: Enter textBilling address : Enter text |

I am unable to undertake the investigations on the following grounds:

|  |
| --- |
| Enter text |

|  |  |  |  |
| --- | --- | --- | --- |
| [Insert Name of Department Head signatory e.g. Dr John Smith] Signature (Head of Department) |  | Date: |  |

*(****Note:*** *If an Investigator is also the Head of Department, sign off should be obtained from the next line of reporting e.g. Divisional Director/Clinical Director)*

*I have discussed this project with* Name of Head of Service Department signatory**,** Insert Service Department name *and appropriate arrangements have been made for this service/department to assist with this project as outlined above.*

|  |  |  |  |
| --- | --- | --- | --- |
| PI Name Signature (Principal Investigator) |  | Date: |  |

**PRINCIPAL INVESTIGATOR DECLARATION**

### Full project title

|  |
| --- |
| Insert Project Title |

I confirm that this project does not require any other Western Health resources/services/departments not already declared on this form. If there are any amendments to the protocol that may impact any new or existing Western Health services, I will ensure that I will discuss them with the departments involved and complete a Statement of Approval to forward onto the Office for Research for acknowledgment.

Principal Investigator Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: [PI Name] Date

1. Sites where the Low Risk Ethics Committee will be responsible for the research participants [↑](#footnote-ref-1)