



Site Screening Questionnaire

Dr. <<name>> along with the Clinical Evaluation Research Unit (CERU) at Queen's University would like to assess your interest in participating as an investigator in the <<Study>>, a clinical trial examining <<brief study description>>.

We request that this questionnaire is completed by the physician or delegated research team member.

Return completed questionnaires to the CERU project office:
 Email:<<PL email>> OR Fax: + 613 548 1351

PART A: Physician Contact Details			
Last Name:		First Name:	
Affiliated Hospital:		Affiliated University:	
Address:		Tel:	
City		Fax:	
Province/State:		Email:	
Postal/Zip Code:		Best Method of Contact:	

PART B: ICU Demographics		
1	Type of institution:	<input type="checkbox"/> Academic <input type="checkbox"/> Community
2	Administrative Structure:	<input type="checkbox"/> Open <input type="checkbox"/> Closed
3	ICU Population:	<input type="checkbox"/> Neuro <input type="checkbox"/> Med/Surg <input type="checkbox"/> Trauma
4	Number of ICU beds:	
5	Number of patients admitted to the ICU annually:	

Part C: Clinical Trials Expertise and Resources		
1	Is the physician and research team familiar with Good Clinical Practice Guidelines for conducting clinical trials?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	How many studies are ongoing at your site? Please list the type of studies (e.g. ARDS, Nutrition, VAP): 1) _____ <input type="checkbox"/> Industry <input type="checkbox"/> Academic 2) _____ <input type="checkbox"/> Industry <input type="checkbox"/> Academic 3) _____ <input type="checkbox"/> Industry <input type="checkbox"/> Academic 4) _____ <input type="checkbox"/> Industry <input type="checkbox"/> Academic 5) _____ <input type="checkbox"/> Industry <input type="checkbox"/> Academic	# studies: ____
3	Will you be available for oversight of study patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Will you be available for resolution of issues pertaining to the study?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Will the investigator be available for regulatory and essential document signatures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Are you planning to use any sub-investigators? If yes, please list: 1) _____ 2) _____ 3) _____ 4) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No



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7	Do you have a research coordinator? If yes, please list contact details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Has your site ever been audited by Health Canada, US FDA or other regulatory agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	How often does your REB meet?	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
10	Does your Pharmacy have resources to support research activities (e.g. randomization, mixing study product, study product accountability)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Do you have a -70 °C freezer? If no, a -20 °C freezer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
PART D: <<Study>>		
1	<<Study specific question...>>	
2		
3		
4		

Please attach a copy of the physician's CV when forwarding the questionnaire responses.

Thank you for taking the time to complete this questionnaire.