# RESEARCH ADVISORY COUNCIL
# BUDGET FORM

( Use additional copy if more space is needed. Write N/A if "not applicable")

I. List all tests which will be performed for the research subjects by the **Dept of Pathology**

| Name of test | # of tests per patient required for routine care | # of tests per patient required in excess of routine care. | # of patients |
|---|---|---|---|
| | | | |
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II. List all examinations which will be performed for the research subjects by the **Dept of Radiology**

| Name of Examination | # of exams per patient required for routine care | # of exams per patient required in excess of routine care | # of patients |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

III. List all tests which will be performed by **Special Labs** such as Pulmonary Function Lab, Neurophysiology Lab and Cardiology Lab

| Name of Test | # of tests per patient required for routine care | # of tests per patient required in excess of routine care | # of patients |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |
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IV. List by title, all **Personnel** involved in this project (Consultant, Scientist, Nurse, Technician etc.)

| Title of Personnel | Working hours per month required for routine medical care of the research subjects | Working hours per month required in excess of routine medical care or for basic research | Duration in months |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

V. **Hospitalisation**

| Type of bed | # of hospitalisation days per patient required for routine care | # of hospitalisation days per patient required in excess of routine care | # of patients |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

VI. **Outpatient** visits

| Name of Clinic | # of clinic visits per patient required for routine care | # of clinic visits per patient required in excess of routine care | # of patients |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Principal Investigator: Name: _____

Signature: _____

Date: _____

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VII. List **Equipment** needed for the study

| Equipment name | # of units required (existing) | # of units required (to be purchased) | Total # of units |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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VIII. List all **Supplies** required for the study, **OR** (for basic research only) multiply total technician(s)'s time (hours) x 40 SR.
(One technician, full time for one year = 4000 hours)

| Name of Supplies | | # of units | Price per unit |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| x 40 SR = SR | | | |
| | | | |

IX. **Pharmacy** cost (transfer from Pharmacy form)

In excess of routine care(experimental + research pharmacist time):

X **Animal Costs** (transfer from Animal Care & Use Form) _____

XI **Statistics**: indicate the estimated number of hours needed: _____

(excludes sponsor-performed statistics)

XII **Publications**

| Type of Publications | # of publications expected | | |
|---|---|---|---|
| Black & White | | | |
| Coloured | | | |
| | | | |

XIII Travel (Use this space for travel directly related to conducting the project (eg., data collection, patient travel if required, consultant visits, training, workshops, etc)

| Destination | Expected # of travel | Duration of Travel (days) | |
|---|---|---|---|
| National | | | |
| Europe | | | |
| North America | | | |
| Other | | | |

Principal Investigator: Name: _____

Signature: _____

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