**STUDY REGistration form**

**Capability and capacity assessment**

**REGISTERING YOUR STUDY WITH R&D**

The Investigator or Sponsor should advise R&D of their interest in conducting a studyat Oxford Health NHS FT **as soon as possible** by completing the below form and emailing it to; [research@oxfordhealth.nhs.uk](mailto:research@oxfordhealth.nhs.uk).

A completed study registration form will be reviewed for feasibility at one of the monthly

Pipeline Meetings. You will be advised of the date of the meeting and the outcome of that review. You may be asked to provide additional information in order that the study can be fully assessed for feasibility.

***Important: If you are using the Cognitive Research Facility (CRF), based at the Warneford Hospital site, you will be required to complete a CRF specific form***

A CRF form should be obtained by contacting the CRF Administrator directly, ([valerie.paulley@oxfordhealth.nhs.uk](mailto:valerie.paulley@oxfordhealth.nhs.uk))

|  |  |  |  |
| --- | --- | --- | --- |
| **Study Details** | | | |
| PID No. (Internal use only) |  | | |
| Date form completed and submitted to R&D | Click here to enter a date. | | |
| Chief Investigator Name (**essential**) |  | | |
| Principal Investigator Name |  | | |
| Study Contact Name  *(if applicable)* |  | | |
| Study Sponsor **(essential)** |  | | |
| Study Title (**essential**) |  | | |
| Is this an educational project?  *Specify which ie. PhD etc* |  | | |
| Is this an NIHR Portfolio study?  *If known what’s the reference number?* |  | | |
| Study duration  *Start & End Dates* |  | | |
| Recruitment duration (in months) |  | | |
| Are you recruiting Healthy Volunteers?  *If yes how many?* |  | | |
| How many OHFT participants required |  | | |
| Is this a single-site study? |  | | |
| Participant age range |  | | |
| Name of Funder |  | | |
| Is your study being supported by the Research Assistants (RAs) based at the Warneford Hospital? |  | | |
| Which area of the Trust will your study run?  (Please tick **all** that apply) | Dementia | Community | Mental Health |
| Please provide more specific detail | Dementia  MCI  Prodromal | Ageing  Dental Oral  Diabetes  Older Adults  Parkinson’s  Stroke  Other | Anxiety  Bipolar  Depression  Eating Disorders  Mood Disorders  Psychosis  Schizo type  Schizophrenia  Suicide |

***For office use only:***

|  |  |
| --- | --- |
| Pipeline Meeting Date: |  |
| Meeting Decision | YES/NO |
| OHFT PID Ref No. |  |
| Signed by Chair of Meeting |  |
| Comments: |  |
| OUTCOME of Meeting | Needs more information  Further Pipeline Review Required  Approved |