

Date : _____

UAB CFAR/1917 Clinic Database, Specimen & Study Coordination Request Form

Principal Investigator (PI)	Name: _____ Title: _____ Department: _____ <small>(if not UAB, list Institution)</small> Trainee: <input type="checkbox"/> Yes <input type="checkbox"/> No (Post-doc, Fellow, Grad Student, or Resident) Address: _____ Phone: _____ Fax: _____ Email: _____
Contact Person (if different than PI)	<input type="checkbox"/> Principal Investigator <input type="checkbox"/> Other: Name: _____ Title: _____ Department: _____ <small>(if not UAB, list Institution)</small> Address: _____ Phone: _____ Fax: _____ Email: _____
Sponsoring Agency/Funding Source	<input type="checkbox"/> No funding source <input type="checkbox"/> Funding source Sponsor _____ UAB OSP sponsor #: _____
Institutional Review Board Approval (IRB) <small>Please Note: Data and/or specimens cannot be released without IRB approval</small> *Please attach approved IRB protocol to this request	<input type="checkbox"/> Approved by UAB or another University WIRB/IRB Approval date: _____ Protocol #: _____ <input type="checkbox"/> Submitted: Pending Approval Submitted date: _____ <input type="checkbox"/> Not submitted Please list your plans for IRB submission with proposed submission date _____ _____ <input type="checkbox"/> Request Regulatory Assistance
Study Title	
Background and Rationale <small>(please limit to 2-3 sentences)</small>	
Type of Request <small>(check all that apply)</small>	<input type="checkbox"/> Specimen Request <input type="checkbox"/> Database Request <input type="checkbox"/> Prospective research study coordination Please allow 2 days for a Research Coordinator to contact you about your prospective research study request.

Start Specimen Request Table:

Sample Size Estimate	
Specimens sent to:	<input type="checkbox"/> Principal Investigator <input type="checkbox"/> Other: Name: _____ Address: _____ Phone: _____ Fax: _____ Email: _____
<input type="checkbox"/> Phenotype #1	
<input type="checkbox"/> Laboratory Data: Current	
	<input type="checkbox"/> Elite Controller <input type="checkbox"/> Viremic Controller <input type="checkbox"/> Acute Infection <input type="checkbox"/> Chronic on ART <input type="checkbox"/> Chronic off ART
<input type="checkbox"/> Viral Load:	<input type="checkbox"/> Any <input type="checkbox"/> Undetectable (<50) <input type="checkbox"/> < 200 <input type="checkbox"/> < 400 <input type="checkbox"/> < 2,000 <input type="checkbox"/> 2,000-10,000 <input type="checkbox"/> 10,000-100,000 <input type="checkbox"/> > 100,000
<input type="checkbox"/> Nadir CD4+:	<input type="checkbox"/> Any % Specimens sorted by Nadir? <input type="checkbox"/> Yes <input type="checkbox"/> No _____
<input type="checkbox"/> CD4+ T Cell Count:	<input type="checkbox"/> Any <input type="checkbox"/> < 200 <input type="checkbox"/> 200-500 <input type="checkbox"/> > 500
<input type="checkbox"/> Current Antiretroviral Therapy:	<input type="checkbox"/> ART Naïve <input type="checkbox"/> On ART (at time of collection) <input type="checkbox"/> Off ART (at time of collection)
<input type="checkbox"/> Basic Demographics (Gender, Race, Age)	
<input type="checkbox"/> Phenotype #2	(repeat)
If you are finished with the Specimen Request, please check the box below, and a research staff member will contact you about your request. Please allow 2 days for a Repository staff member to contact you. <input type="checkbox"/> Finished with Specimen Request If you would like more Data Elements with your request, please check the box below. <input type="checkbox"/> Add more Data Elements to Specimen Request	

Start Database Request Table:

Study Aims: Describe what you would like to accomplish with this data request	
Population for this data (ex: All patients with first visit to 1917 clinic primary care)	
Time Points for this data (month/year) *Please note that any data from dates prior to 2004 constitute a minimum of "Complex" level query	_____ to _____
Data Collection/Analysis Needs: describe data collection, measurement, queries, tracking tools, web-based programming, etc.	
Preferred Method of Delivery: Please clarify preferred method of delivery (ex: 1917 Clinic I drive, UAB drop box, etc) and discuss any specific requests involving file type, data delivery, or other comments)	
All of the following data elements must be clearly defined on your IRB proposal. If not, you will be contacted by a research staff member to amend your IRB and/or data request. Please allow 2 days for an Informatics staff member to contact you.	
<input type="checkbox"/> Demographics	
<input type="checkbox"/> Gender	<input type="checkbox"/> Age
<input type="checkbox"/> Race/Ethnicity	<input type="checkbox"/> HIV Risk Factor
<input type="checkbox"/> Identifiers:	<input type="checkbox"/> SSN <input type="checkbox"/> Medical Record Number <input type="checkbox"/> REPO number <input type="checkbox"/> Name <input type="checkbox"/> Phone Number <input type="checkbox"/> Date of Birth
<input type="checkbox"/> Residence:	<input type="checkbox"/> Zip Code <input type="checkbox"/> City <input type="checkbox"/> State <input type="checkbox"/> County
<input type="checkbox"/> Antiretroviral History	
<input type="checkbox"/> Therapeutic:	<input type="checkbox"/> ART- naïve <input type="checkbox"/> Current ART <input type="checkbox"/> ART history
<input type="checkbox"/> Laboratory Data/Vitals	
<input type="checkbox"/> Laboratory (HIV associated):	<input type="checkbox"/> Plasma HIV RNA <input type="checkbox"/> CD4 count (%)
<input type="checkbox"/> Laboratory (non-HIV associated):	<input type="checkbox"/> Blood counts <input type="checkbox"/> Chemistries <input type="checkbox"/> Lipid profiles <input type="checkbox"/> Viral hepatitis serologies <input type="checkbox"/> Other: _____
<input type="checkbox"/> Vitals:	<input type="checkbox"/> Blood Pressure <input type="checkbox"/> Height <input type="checkbox"/> Weight
<input type="checkbox"/> Clinical	
<input type="checkbox"/> HIV/AIDS Diagnosis:	<input type="checkbox"/> Date of HIV diagnosis
<input type="checkbox"/> OIs:	<input type="checkbox"/> OIs or AIDS-related dx with date of diagnosis
<input type="checkbox"/> Primary HIV Care Attendance:	<input type="checkbox"/> Scheduled 1917 Visits with Status
<input type="checkbox"/> Other Clinical Care:	<input type="checkbox"/> Specialty clinics at 1917 visit dates <input type="checkbox"/> Specialty clinics within UAB Healthcare system visit dates <input type="checkbox"/> Hospitalization (admission dates to UAB Hospital system)

<input type="checkbox"/> Concurrent treatments:	<input type="checkbox"/> Non-ARV medication <input type="checkbox"/> Medication Allergies <input type="checkbox"/> Immunizations
<input type="checkbox"/> Death:	<input type="checkbox"/> Date of Death <input type="checkbox"/> Cause of Death
<input type="checkbox"/> Clinical (other events):	<input type="checkbox"/> Specific other diagnoses (please list): _____
<input type="checkbox"/> Socioeconomic:	<input type="checkbox"/> Insurance type (Public, Private, Uninsured) <input type="checkbox"/> Other _____
<input type="checkbox"/> Patient Reported Outcomes (self-reported): *since 2008	<input type="checkbox"/> EuroQOL (Quality of Life) <input type="checkbox"/> FRAM (Body Morphology) <input type="checkbox"/> HIV Symptoms Index (Symptom Burden) <input type="checkbox"/> Tobacco Use <input type="checkbox"/> ACTU-4 (Adherence) <input type="checkbox"/> PHQ-9 (Depression) <input type="checkbox"/> ASSIST (Drugs) <input type="checkbox"/> PHQ-A (Anxiety) <input type="checkbox"/> AUDIT-C (Alcohol Consumption)
Please specify any additional details/items:	

If you have any problems with submission of this form, please contact Andy Wood at awood@uab.edu or call 205-996-6337.