Date : _____

UAB CFAR/1917 Clinic Database, Specimen & Study Coordination Request Form	
Principal Investigator (PI)	Name:_____ Title: _____ Department:_____ (if not UAB, list Institution) Trainee: ☐ Yes ☐ No (Post-doc, Fellow, Grad Student, or Resident) Address:_____ Phone:_____ Fax:_____ Email:_____
Contact Person (if different than PI)	☐ Principal Investigator ☐ Other: Name:_____ Title: _____ Department:_____ (if not UAB, list Institution) Address:_____ Phone:_____ Fax:_____ Email:_____
Sponsoring Agency/Funding Source	☐ No funding source ☐ Funding source Sponsor_____ UAB OSP sponsor #:_____
Institutional Review Board Approval (IRB) Please Note: Data and/or specimens cannot be released without IRB approval ***Please attach approved IRB protocol to this request**	☐ Approved by UAB or another University WIRB/IRB Approval date:_____ Protocol #:_____ ☐ Submitted: Pending Approval Submitted date:_____ ☐ Not submitted Please list your plans for IRB submission with proposed submission date _____ _____ ☐ Request Regulatory Assistance
Study Title	
Background and Rationale (please limit to 2-3 sentences)	
Type of Request (check all that apply)	☐ Specimen Request ☐ Database Request ☐ 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:	☐ Principal Investigator ☐ Other: Name:_____ Address:_____ Phone:_____ Fax:_____ Email:_____
☐ Phenotype #1	
☐ Laboratory Data: Current	
	☐ Elite Controller ☐ Viremic Controller ☐ Acute Infection ☐ Chronic on ART ☐ Chronic off ART
☐ Viral Load:	☐ Any ☐ Undetectable (<50) ☐ < 200 ☐ < 400 ☐ < 2,000 ☐ 2,000-10,000 ☐ 10,000-100,000 ☐ > 100,000
☐ Nadir CD4+:	☐ Any % Specimens sorted by Nadir? ☐ Yes ☐ No _____
☐ CD4+ T Cell Count:	☐ Any ☐ < 200 ☐ 200-500 ☐ > 500
☐ Current Antiretroviral Therapy:	☐ ART Naïve ☐ On ART (at time of collection) ☐ Off ART (at time of collection)
☐ Basic Demographics (Gender, Race, Age)	
☐ 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. ☐ Finished with Specimen Request If you would like more Date Elements with your request, please check the box below. ☐ 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.	
☐ Demographics	
☐ Gender ☐ Age	☐ Race/Ethnicity ☐ HIV Risk Factor
☐ Identifiers:	☐ SSN ☐ Medical Record Number ☐ REPO number ☐ Name ☐ Phone Number ☐ Date of Birth
☐ Residence:	☐ Zip Code ☐ City ☐ State ☐ County
☐ Antiretroviral History	
☐ Therapeutic:	☐ ART- naïve ☐ Current ART ☐ ART history
☐ Laboratory Data/Vitals	
☐ Laboratory (HIV associated):	☐ Plasma HIV RNA ☐ CD4 count (%)
☐ Laboratory (non-HIV associated):	☐ Blood counts ☐ Chemistries ☐ Lipid profiles ☐ Viral hepatitis serologies ☐ Other:_____
☐ Vitals:	☐ Blood Pressure ☐ Height ☐ Weight
☐ Clinical	
☐ HIV/AIDS Diagnosis:	☐ Date of HIV diagnosis
☐ OIs:	☐ OIs or AIDS-related dx with date of diagnosis
☐ Primary HIV Care Attendance:	☐ Scheduled 1917 Visits with Status
☐ Other Clinical Care:	☐ Specialty clinics at 1917 visit dates ☐ Specialty clinics within UAB Healthcare system visit dates ☐ Hospitalization (admission dates to UAB Hospital system)

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

Submit

If you have any problems with submission of this form, please contact Sarah Dougherty at sarahdougherty@uabmc.edu or call 205-996-5241.