**GI Cohort and IBD Cohort request form**

Please complete this request form and e-mail to [TGU-admin@ndm.ox.ac.uk](mailto:TGU-admin@ndm.ox.ac.uk)

\*Request forms are reviewed each month at the TGU Internal Committee meeting. ***Please note that the Lead Applicant or contact person may be required to attend this meeting which is held via Teams on the third Thursday of the month***

|  |  |  |
| --- | --- | --- |
| \*Nominated person to attend the TGU Teams meeting if requested by the committee | |  |
| Email address (*you will be sent a link to join the meeting via email)* | |  |
| Is this a new request or an amendment to an existing TGU project?  (If making an amendment, please include TGU reference here. Reference can be found on your TGU approval letter. Please highlight any amendments to your original request in RED) | |  |
| Date | |  |
| Section 1 Applicant and personnel details | | |
| Research group / department | |  |
| Lead applicant *(e.g. Head of Department or Group, or clinical trial PI)* | **Name** |  |
| **Email** |  |
| Contact person *(i.e. the person who will coordinate the request(s) withTGU)* | **Name** |  |
| **Email** |  |
| Collaborators | **Names** |  |
| Consenters and Data entry personnel (*Consenters must be GCP certified and trained using our SOP.)* | **Names** |  |
| NHS Personnel *(endoscopist, pathologists and/or surgeon)* | **Names** |  |
| Section 2 Funding | | |
| Research funder (*e.g. commercial company, NHS or University)* | |  |
| Section 3 Ethics | | |
| Ethical approval details *(GI Ethics, IBD Ethics or your own. Please note that it is your responsibility to ensure that your project is covered by Ethics.)* | |  |
| Section 4 Project details | | |
| Research project title | |  |
| Planned Study Period | |  |
| Follow-up Duration | |  |
| Summary of Project | |  |
| Aims and objectives *(Scientific background, plan of*  *investigation, methodology and any pilot data)* | |  |
| Summary of the project in layman’s terms | |  |
| Will your project involve any questionnaires or patient correspondence? Yes/No | |  |
| Sample details | | |
| Interventions (*Where will you be getting samples from? Clinics, surgery, etc.)* | |  |
| Sample requirements  (*Sample numbers and description of samples required)* | |  |
| Full details of histology services  *(e.g. number of sections required, staining, processing)* | |  |
| How will material be used?  Will you be shipping samples? Please give details. | |  |
| Data requirements  *(Specify any accompanying data you require e.g. copy of pathology reports)* | |  |
| For TGU use:  Approval date/ comments | |  |