**SCHEDULER TEMPLATE SET UP**

**COMIRB Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Protocol Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Contact (Name and Phone): ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Physician (if not PI): ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List of all CTRC study visits (names should match OnCore):**

For each visit, please specify the following information:

* Inpatient or Outpatient
* Room type (table and chairs, exam table, bed, or procedure)
* Length of time the room is needed
* Nursing services needed (blood draw, EKG, urine, etc)
* Other core services (PA/NP, Echo, DXA, etc)?

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| --- | --- | --- | --- | --- |
| **Visit Type (Inpatient vs Outpatient)** | **Title of Visit in OnCore** | **Type of Room needed for Visit? (Table, Exam Table, Bed/procedure)** | **CTRC Resources Needed? (CTRC PA/NP, Dexa, Parvo, EKG, mobile nursing)** | **Estimated Total Visit Time** |
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