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Heading font: 14 pts Bold
Subheading Font: 12pts Bold

TITLE OF SYNOPSIS

THESIS PROPOSAL SUBMITTED TO SRI GURU RAM DAS UNIVERSITY OF HEALTH SCIENCES, AMRITSAR TOWARDS PARTIAL FULFILLMENT OF REQUIREMENT FOR THE AWARD OF

MASTER OF SCIENCE

IN

MEDICAL (SPECIALIZATION NAME)

UNDER THE FACULTY OF MEDICAL SCIENCES

BY

STUDENT NAME

SUPERVISOR

NAME

DEPARTMENT OF ……., SGRDIMSR

SRI GURU RAM DAS UNIVERSITY OF HEALTH SCIENCES, AMRITSAR

To

The Registrar,
Sri Guru Ram Das University of Health Sciences,
Sri Amritsar.

Subject: Submission of Synopsis

Sir,

I am submitting my synopsis entitled, **"……"** required in partial fulfilment for the award of Master of Science in subject of …….. for your kind approval.

Thanking you

Yours faithfully,

Department of

Name of the student (Capital letters)	
Enrollment Number	
Date of Birth	
Permanent Residential Address	
E-mail id and Mobile Number	
Father Name	
Mother Name	
Month and Year of Passing Bachelor Degree	
Name of Institute from where passed Bachelor Degree	
Name of University from where passed Bachelor Degree	
Date of joining the Programme	
Signature of Candidate	

SRI GURU RAM DAS UNIVERSITY OF HEALTH SCEINCES, AMRITSAR
CERTIFICATE OF FACILITIES AVAILABLE

SRI GURU RAM DAS UNIVERSITY OF HEALTH SCEINCES, SRI AMRITSAR

CERTIFICATE OF FACILITIES AVAIABLE

This is to certify that facilities for work on the subject of thesis titled "……..……" exists at SGRDUHS, Amritsar and will be provided to the candidate. We will see that the data being included in the thesis are genuine and is collected by the candidate himself/herself under our supervision and guidance. The research project has been thoroughly discussed in the department of ……

Signature of Head of Department

Signature of Supervisor

Signature of Co-Supervisor

Signature of Principal

DECLARATION BY THE CANDIDATE

I, ……..hereby declare that the work embodied in the thesis entitled“…….. ……” will be an original work carried out by me under the guidance of my supervisor Dr…… and Co-supervisors Dr ……. in the department of ……

Signature

APPROVAL PROFORMA
FOR RESEARCH & ETHICAL COMMITTEE
SRI GURU RAM DAS UNIVERSITY OF HEALTH SCIENCES, AMRITSAR

Name of candidate	
Department	
Topic of Thesis	
Year of Course work completion	
Date of enrollment	
Name of Head of Department	
Supervisor **Co-Supervisor**	
Signature of Members of Research Committee with Stamp	**Signature of Members of Ethics Committee with Stamp**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5
6.	6.
7.	7.

Approved : Yes / No **Approved : Yes /No**

Chairperson **Chairperson**

1.0. Title of thesis:

The title should be in capital letters. It should be concise, specific and reflect the proposed project to be undertaken. Scientific names in the title, if any, must be written in Latin binomial or trinomial.

2.0. Introduction

This section should highlight the scope and significance of the proposed project work along with the **knowledge gaps** and **objectives** of the study under separate sub-heads.

2.1. Objectives

3.0. Rationale of the study and Hypothesis

Significance of the study should be clearly indicated

4.0. Review of literature

An up-to-date and comprehensive review of literature indicating history, developments and IPR (if any) relating to the topic of the proposed project should be given.

5.0. Materials and Methods

5.1. Name and location of experiment

5.2. Materials to be used along with source:

This section should mention the details of the work to be carried out under following heads:

Setting:

a. **Duration of experiment**:
b. **Type of study**:
c. **Participants**:
d. **Sample size**:
e. **Formula of sample size calculation:**
f. **Inclusion criteria**:
g. **Exclusion criteria**:

6.0. Activity Schedule

6.1. Observations to be recorded

6.2. Statistical analysis

7.0. Collaborating department/institution(s), if any.

Consent of the head of concerned collaborating department/institution should be obtained and it should be a part of the synopsis. The extent of work to be carried out in collaborating department/

institution should be clearly mentioned including the sharing of resources, expenditure involved and Intellectual Property Rights.

8.0. References

All the references used in preparing the synopsis should be listed at the end (Please follow Vancouver or APA style).

Recommendations and forwarding:

The supervisor/co-supervisor and members of research advisory committee of the scholar shall sign the synopsis with date and place before its submission to the concerned head of department for transmission to Chairman, institutional Research Committee for processing of synopsis for approval.

***= Proper consent form duly approved by Sri Guru Ram Das University of Health Sciences in a language understood by the participant in the study must be filled and got signed by the participant. This must be verified by the supervisor and maintained in a file by the concerned department till the results are published.**

Patient case Performa

Patient general information **Date:**

Patient name	
Age	
Address/Area	
Phone no.	
OPD/CR no.	
Rural/Urban	
Educational Status	
Marital Status	
Occupation	

Presenting complains:-

Present illness	
Site of the problem	
When & how it started	
Any pain	
How your problem gets affected	

Past History

Any significant disease	
Any hospitalization	
Any treatment and its duration	

Family history

Any family history of disease
General physical examination

Specimen Collected	

Signature of Supervisor/Co-Supervisor: **Signature of Candidate:**

INFORMED CONSENT DOCUMENT (ICD) PART-I

Patient / Participant information sheet

INFORMATION FOR PARTICIPANTS OF THE STUDY

Introduction:

Patient information sheet includes the introduction and significance/outcome of the study.

- Title of the project
- Name of the Supervisor
- Purpose of this project/study
- Procedure/methods of the study
- Expected duration of the subject participation
- The benefits to be expected from the research to the participant or to others
- Any risks expected from the study to the participant
- Maintenance of confidentiality of records
- Freedom to withdraw from the study at any time during the study period without the loss of benefits that the participant would otherwise be entitled

Signature of the Supervisor:

Signature of the participant:

Place:

Date:

INFORMED CONSENT DOCUMENT (ICD) PART-2

INFORMED CONSENT FORM

Title of the project:

Participant's name:

Address:

The details of the study have been provided to me in writing and explained to me in my own language. I confirm that I have understood the above study and had the opportunity to ask questions. I confirm that I have understood about the compensation and the risks and benefits involved in this research. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving any reason, and without my routine medical care in this hospital being affected. I understand that confidentiality of my identity will be maintained during the research period, after its completion as well as during publication of the results. Only investigator, ethics committee, institutional or regulatory authorities may have access to my information when required.

I have been given a copy of information sheet giving details of the study.

I volunteer to participate in the above-mentioned study.

(I also consent/do not consent to use of my stored biological samples or related data for future scientific purposes, if applicable)

(I also consent/do not consent to be contacted over telephone for study purposes/ knowing the results – if applicable)

Name and Signature/thumb impression of the participant: _____Date: _____

Signature of the witness with date: _____ Date: _____

Name and address of the witness for illiterate participants:

Signature of the investigator with date: _____Date: _____

CONSENT FORM FOR PARENT/ LEGALLY ACCEPTABLE REPRESENTATIVE (LAR)

(for participants less than 18 years of age and for patients who cannot consent)

Title of the project:

Participant's name:

Address:

Parent/LAR' s name:

The details of the study have been provided to me in writing and explained to me in my own language. I confirm that I have understood the above study and had the opportunity to ask questions. I confirm that I have understood about the compensation and the risks and benefits involved in this research. I understand that my child's/ward's participation in the study is voluntary and that I am free to withdraw at any time without giving any reason, and without my child's/ward's routine medical care in this hospital being affected. I understand that confidentiality of my child's/ward's identity will be maintained during the research period, after its completion as well as during publication of the results. Only investigator, ethics committee, institutional or regulatory authorities may have access to my my child's/ward's information when required. I have been given a copy of information sheet giving details of the study. I volunteer my child/ward to participate in the above mentioned study.

Verbal assent taken for children 7-12 year of age: Yes/No

(I also consent/ do not consent to use of my child's/ward's stored biological samples or related data for future scientific purposes, if applicable)

(I also consent / do not consent to be contacted over telephone for study purposes/ knowing the results – if applicable)

Name and Signature/thumb impression of the parent/LAR: _____Date: _____

Signature of the witness with date: _____ Date: _____ Name and

address of the witness for illiterate participants:

Signature of the investigator with date: _____Date: _____

ASSENT FORM TO PARTICIPATE IN A CLINICAL RESEARCH

(for children above 12 years and below 18 years of age)

Child Participant's name:

Date of birth/Age:

Parent/LAR' s name:

Address:

Title of the project:

We are doing a research study about .....(purpose in simple language). In this study we will be ..... (description of the study - Procedures, Drugs to be used, risks, discomfort, in simple language). The possible benefits from this study might be ..... (details of possible benefits of participation) If you do not want to be in this research study, we will tell you other options (for research projects that offer treatment or intervention). When we are complete the study, we will write a report about what was learned. This report will not include your name or that you were in the study. You can be in this study if you want to be. If you decide to stop after we begin, that's fine too. Your parents know about the study too. If you decide you want to be in this study, please sign your name.

I, _____, want to be in this research study.

Signature of the child participant: Date:

(If child knows to sign/Thumb impression)

Signature of the parent or guardian: Date:

Name and address of the witness:

Signature of the witness: Date:

Signature of the Investigator: Date:

(Assent form should be accompanied by patient / participant information sheet for children in a simple language comprehensible to a child of 7-18 years; Language used should be simpler for children in the age group 7-12 years compared to children in the age group >12-18 years)

CONSENT FOR STUDY

I_____, son/daughter of _____ resident of _____ am participating in this research study voluntarily, and my decision to do so will not affect my treatment in this institution in any way. Whole study and its procedures have been well explained to me in the language I can understand best. I understand that the risks in this procedure are none or minimal. I will not be given any compensation or payment for participation in the study. When the results of this research are published or discussed in conferences, no information that may reveal my identity will be disclosed. I can withdraw from this study at any time and for any reason. I am not giving up any of my legal rights by signing this form.

_____ _____

Signature/ thumbprint of witness Signature/ thumbprint of participant Name of witness: Name of participant:

Date:

Signature of Investigator:

शोध अध्ययन में भागीदारी के लिए सहमति

मैं

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..... सभी अध्ययन और प्रशिक्षण कार्यक्रम को मुझे उस भाषा में अच्छी तरह समझाया गया है जिसे मैं सबसे अच्छा समझ सकता हूं। मुझे अध्ययन में भाग लेने के लिए कोई मुआवजा या भुगतान नहीं दिया जाएगा। जब इस शोध के परिणाम सम्मेलनों में प्रकाशित या चर्चा की जाती हैं, तो मेरी पहचान प्रकट करने वाली कोई भी जानकारी प्रकट नहीं की जाएगी। मैं इस अध्ययन से किसी भी समय और किसी भी कारण से वापस ले सकता हूं। मैं इस फॉर्म पर हस्ताक्षर करके अपने किसी भी कानूनी अधिकार को नहीं छोड़ रहा हूं।

प्रतिभागी का हस्ताक्षर

तारीख:

जांचकर्ता का हस्ताक्षर

ਖੋਜ ਦੇ ਅਧਿਐਨ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤੀ

ਮੈ_____,_____ਦਾ..ਬੇਟਾ _____
_____ ਦਾ ਨਿਵਾਸੀ ਇਸ ਵਿਚ ਹਿੱਸਾ ਲੈ ਰਿਹਾ ਹਾਂI ਖੋਜ ਅਭਿਆਸ ਦੀ ਸਵੈ-ਇੱਛਾ ਨਾਲ, ਅਤੇ ਇਸ ਤਰ੍ਹਾਂ ਕਰਨ ਦਾ ਮੇਰਾ ਫੈਸਲਾ ਕਿਸੇ ਵੀ ਤਰਾ ਨਾਲ ਇਸ ਸੰਸਥਾ ਵਿੱਚ ਮੇਰੇ ਇਲਾਜ ਨੂੰ ਪ੍ਰਭਾਵਤ ਨਹੀਂ ਕਰੇਗਾ। ਪੂਰੇ ਅਧਿਅਨ ਅਤੇ ਇਸ ਦੀਆਂ ਪ੍ਰਕ੍ਰਿਆਵਾਂ ਨੇ ਮੇਰੀ ਭਾਸ਼ਾ ਦੀ ਚੰਗੀ ਤਰ੍ਹਾਂ ਵਿਆਖਿਆ ਕੀਤੀ ਹੈ ਜੋ ਮੈਂ ਸਭ ਤੋਂ ਚੰਗੀ ਤਰ੍ਹਾਂ ਸਮਝ ਸਕਦਾ ਹਾਂ। ਮੈਂ ਸਮਝਦਾ/ਸਮਝ ਦੀ ਹਾਂ ਕਿ ਇਸ ਪ੍ਰਕਿਰਿਆ ਵਿਚ ਜੋਖਮ ਕੋਈ ਨਹੀਂ ਜਾਂ ਘੱਟੋ ਘੱਟ ਹਨ। ਮੈਨੂੰ ਅਧਿਐਨ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਕੋਈ ਮੁਆਵਜ਼ਾ ਜਾਂ ਨਹੀਂ ਦਿੱਤਾ ਜਾਏਗਾ । ਜਦੋਂ ਇਸ ਖੋਜ ਦੇ ਨਤੀਜਿਆਂ ਨੂੰ ਪ੍ਰਕਾਸ਼ਿਤ ਕੀਤਾ ਜਾਂਦਾ ਹੈ ਜਾਂ ਕਾਨਫਰੰਸਾਂ ਵਿੱਚ ਵਿਚਾਰਿਆ ਜਾਂਦਾ ਹੈ, ਤਾਂ ਮੇਰੀ ਪਛਾਣ ਪ੍ਰਗਟ ਕਰਨ ਵਾਲੀ ਕੋਈ ਵੀ ਜਾਣਕਾਰੀ ਪ੍ਰਗਟ ਨਹੀਂ ਕੀਤੀ ਜਾਵੇਗੀ । ਮੈਂ ਕਿਸੇ ਵੀ ਸਮੇਂ ਅਤੇ ਕਿਸੇ ਵੀ ਕਾਰਨ ਕਰਕੇ ਇਸ ਅਧਿਐਨ ਤੋਂ ਵਾਪਸ ਲੈ ਸਕਦਾ ਹਾਂ । ਮੈਂ ਇਸ ਫਾਰਮ 'ਤੇ ਹਸਤਾਖਰ ਕਰਕੇ ਮੇਰੇ ਕਿਸੇ ਵੀ ਕਾਨੂੰਨੀ ਅਧਿਕਾਰ ਨੂੰ ਨਹੀਂ ਛੱਡ ਰਿਹਾ ।

ਗਵਾਹ ਦੇ ਹਸਤਾਖਰ

ਅੰਗੂਠਾ ਭਾਗੀਦਾਰ ਦੇ ਹਸਤਾਖਰ/

ਅੰਗੂਠਾ / ਗਵਾਹ ਦਾ ਨਾਮ: ਭਾਗੀਦਾਰ ਦਾ ਨਾਂ:

ਤਾਰੀਖ:

ਜਾਂਚ ਕਰਤਾ ਦੇ ਹਸਤਾਖਰ: