



The Cochrane Peripheral Vascular Diseases Group Proposal for a new Cochrane Review

Please complete and email this form to h.g.maxwell@ed.ac.uk.
Heather Maxwell, Review Group Co-ordinator, Cochrane Peripheral Vascular Diseases Group,
Public Health Sciences, The Medical School, The University of Edinburgh,
Teviot Place, Edinburgh EH8 9AG.
Tel: +44 131 6503206 Fax: +44 131 6506904

Authors completing this form must note that they are required to read and follow The Cochrane Handbook for Systematic Reviews of Interventions in preparing their review <http://www.cochrane.org/resources/handbook/index.htm>

Proposed Title (Using Standard Format)

Motivation for the Review (Is this part of a PhD, is it topical?)

Description of proposal (Your proposal should not overlap with reviews already published or underway. Please refer to the PVD website or contact the editorial base for details of registered titles.)

(a) **Objective** (What is the research question?)

(b) **Rationale for review** (Why is this review important? You may provide citations of relevant papers.)

For information on the following sections, please refer to section 4.2 of the Cochrane Handbook for Systematic Reviews of Interventions (<http://www.cochrane.org/cochrane/handbook/hbook.htm>)

(c) **Types of study** (These will generally be randomised controlled trials.)

(d) **Participants** (What sort of participants will the relevant studies have recruited? You may want to define them in terms of age or gender, duration of problem etc.)

(e) **Interventions and specific comparisons to be made** (What interventions are you interested in assessing? The intervention could be a drug, surgical technique, physical treatments, exercise etc.) What are you comparing the intervention with? The comparison may be against no treatment, placebo, other drug, or alternative surgical technique etc.)

(f) **Outcomes** (What outcomes do you think are important? Remember to consider outcomes that patients consider the most important e.g. pain, side effects, quality of life.)

(g) **What subgroup analysis do you intend to undertake?** (Will certain factors be investigated for their influence on the treatment effect e.g. dose, duration etc.)

(h) **Other information relevant to this proposal** (relevance to consumers, and ideas for consumer input into review.)

Review author team and area of expertise

	Name	Area of expertise <i>(please indicate the background and skills of each review author and the expertise they bring to the review team e.g. content, methodology; statistics)</i>
Contact author:		
Co-author(s) :		

Do you or your co-authors have any interests in this topic that could be perceived as conflicts of interest?

Cochrane Reviews should be free of any real or perceived bias introduced by the receipt of any benefit in cash or kind, any hospitality, or any subsidy derived from any source that may have or be perceived to have an interest in the outcome of the review. It is a matter of Cochrane Collaboration policy that direct funding from a single source with a vested interest in the results of the review is not acceptable.

See <http://www.cochrane.org/docs/commercialsponsorship.htm>

Yes No

If 'yes', what are they?

Is this review the subject of specific funding and/or does it need to be finished within a specific timeframe? If yes, please give details.

Has the review already been carried out or published?

If yes, where has it been published?

Roles and responsibilities

TASK	WHO HAS AGREED TO UNDERTAKE THE TASK?
Draft the protocol	
Develop a search strategy	
Search for trials (usually 2 people)	
Obtain copies of trials	
Select which trials to include (2 + 1 arbiter)	
Extract data from trials (2 people)	
Enter data into RevMan	
Carry out the analysis	
Interpret the analysis	
Draft the final review	
Update the review	

Other information

Have you or a co-author written a systematic review before?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, was it a Cochrane Review?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a copy of the Cochrane Handbook for Systematic Reviews of Interventions?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you attended a Cochrane Review training workshop?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, which one?.....	
If no, are you planning to? Which one?.....	
Do you have a copy of RevMan 4.2.8, the Cochrane Review Manager software?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you seen the Cochrane PVD Review Group website?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
What type of computer do you use?.....	Mac <input type="checkbox"/> PC <input type="checkbox"/>
Do you have ready access to email and the internet?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have access to:	
<i>The Cochrane Library</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
MEDLINE	Yes <input type="checkbox"/> No <input type="checkbox"/>
PubMed	Yes <input type="checkbox"/> No <input type="checkbox"/>
EMBASE	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have access to a medical library:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, can you order journal articles not held in the Library?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have access to reference management software:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, which software, and what version?	
Do you require assistance with:	
Using RevMan (currently version 4.2.8)?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Searching <i>The Cochrane Library</i> ?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Translation of articles?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Training?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Access to a statistician (strongly recommended)?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Contact with consumer groups?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seeking funding/scholarship opportunities?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you predominantly speak/write in a language other than English?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>

Provisional dates for submission of drafts to editorial base

(A) Draft PROTOCOL

(B) Draft REVIEW

Agreement to Editorial Review and Publication in The Cochrane Library

By completing this title registration form, you agree to submit a draft protocol within three months. If there is no correspondence from you during this period, or no draft protocol has been received, the Cochrane Review Group reserves the right to de-register the title or transfer the title to a new author.

By completing and returning this form, you are accepting responsibility for maintaining and updating the review in accordance with Cochrane Collaboration policy, i.e. you will be responsible for ensuring the review is updated at least every two years. If you are unable to update this review the Review Group reserves the right to transfer the review to a new author.

The support of the editorial team in producing your review is conditional upon your agreement to publish the protocol and finished review, together with subsequent updates, in The Cochrane Library. By completing and signing this form you undertake to publish firstly in The Cochrane Library (concurrent publication in other journals may be allowed in certain circumstances with prior permission of the editorial team.).

I understand the long-term commitment necessary when undertaking a Cochrane Review.

Form completed by: Date:

Details of contact author

Prefix (e.g. Ms, Dr):

First name: Family name:

Job title/Position

Department:

Organisation:

Address:

City:

Region/State:

Post/Zip code: Country:

Telephone number: Fax number:

Mobile number:

Email address:

Privacy: Hide address details Yes No
Hide email address Yes No

Country of origin: Gender: Female Male

Details of co-author(s)

Prefix (e.g. Ms, Dr):

First name: Family name:

Job Title/Position:

Department:

Organisation:

Street/Address:

City:

Region/State:

Post/Zip code: Country:

Telephone number: Fax number:

Mobile number:

Email address:

Privacy: Hide address details Yes No
Hide email address Yes No

Country of origin: Gender: Female Male

Details of co-author(s)

Prefix (e.g. Ms, Dr):

First name: Family name:

Job Title/Position:

Department:

Organisation:

Street/Address:

City:

Region/State:

Post/Zip code: Country:

Telephone number: Fax number:

Mobile number:

Privacy: Hide address details Yes No
Hide email address Yes No

Country of origin: Gender: Female Male

Details of co-author(s)

Prefix (e.g. Ms, Dr):

First name: Family name:

Job Title/Position:

Department:

Organisation:

Street/Address:

City:

Region/State:

Post/Zip code: Country:

Telephone number: Fax number:

Mobile number:

Email address:

Privacy: Hide address details Yes No
Hide email address Yes No

Country of origin: Gender: Female Male

Details of co-author(s)

Prefix (e.g. Ms, Dr):

First name: Family name:

Job Title/Position:

Department:

Organisation:

Street/Address:

City:

Region/State:

Post/Zip code: Country:

Telephone number: Fax number:

Mobile number:

Privacy: Hide address details Yes No
Hide email address Yes No

Country of origin: Gender: Female Male

Thank you for completing this form.

For office use only

1. Approved title:

.....

2. Approved by:

(a) Name:

Role **Date approved**

(b) Name:

Role: **Date approved**

3. Review number:

4. Contact identifiers:

5. Date registered in IMS:

6. Notes (e.g., CRGs who will provide referees)