**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Boston Medical Center**

**Radiology Research Study Form**

**Title of Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Principal Investigator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Study Coordinator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Department Administrator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sponsor/Corporation/NIH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phase:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is study IRB or WIRB (circle one) approved? ⬜ Yes ⬜ No Is study Budget approved? ⬜ Yes ⬜ No**

**Multi-center? ⬜ Yes ⬜ No**

**Study Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy number (SDK as assigned by BMC grants admin):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is any part of this study being handled by the GCRC?: ⬜ Yes ⬜ No If yes explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Types of Imaging Services Required**

**(Please check modality and the area in Radiology where services will be performed)**

**⬜ CT: Slice: ⬜64 ⬜ Menino ⬜ ENC**

**⬜MRI: ⬜1.5T ⬜ 3.0T ⬜ Menino ⬜ ENC ⬜ Shapiro**

**⬜Ultrasound: ⬜ Menino ⬜ ENC ⬜ Shapiro**

**⬜Mammography: ⬜ Moakley**

**⬜Nuclear Medicine: ⬜ ENC ⬜ Moakley**

**⬜X-Ray: ⬜ Menino ⬜ ENC ⬜ Shapiro**

**Does your project require study specific imaging parameters/guidelines?**

*(If* **yes** *please attach imaging guidelines, if* **no** *we will follow standard of care***) ⬜ Yes ⬜ No**

**Do these scans need oral contrast ⬜ , IV contrast ⬜ , or Both ⬜ ?**

**Do these studies need Clinical Reads?** **⬜ yes (your administrator will be invoiced directly for the pro fees) ⬜ no CRFs? ⬜ yes ⬜ no**

**Will CDs/DVDs need to be burned? \_\_\_\_\_\_\_How many? \_\_\_\_ If so provide info (you will be responsible for labeling the CD/DVD-provide sample of how you will label:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of patients expected to be enrolled at this site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expected start date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Duration of study:\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments**

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| **FEES-for radiology use only** |
| **Centricity Research Code** | **CPT codes** | **Tech Fee** | **Professional Fee** |
|  |  |  |   |