**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 (assigned by BMC CTO for Velos):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BUMC IRB #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BU Internal Order Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMC Accounting Unit Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 ⬜ 16 ⬜ DUAL ⬜ Menino**

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

**⬜ Ultrasound: ⬜ Menino ⬜ Shapiro**

**⬜ Mammography: ⬜ Moakley**

**⬜ Nuclear Medicine: ⬜ Moakley**

**⬜ X-Ray: ⬜ Menino ⬜ 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 ⬜ Oral Contrast & IV Contrast ⬜**

**Do these studies need Clinical Reads?** **⬜ Yes ⬜ No**

**Case Report Forms (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** |  **Fee** | **Professional Fee** |