MGUH Radiology Research Support Request Form

Requesting Department Information

Department Name: ____________________________                     Contact Person (CRC, etc.):_________________________
Principal PI Name: _____________________________                    Contact Person Phone #:___________________________
Principal PI Email: _____________________________                    Contact Person Email: _____________________________

Project Information

Project start date:__________________      Project end date:_________________________                IRB#___________________
Study Title: ___________________________________
Study sponsor:___________________________________
Grant number/Worktags:_______________________  Total # of subjects to be enrolled: _____________________

List Procedures (imaging and/or bx) Being Requested and Frequency (e.g. TAP CT with contrast Q6 weeks)

Special notes/requests: _______________________________________________________________________
Imaging location:       MGUH       Other MedStar site   Specify: _______________
Imaging Modality:             CT             X-Ray/Fluoro            MRI           Nuclear               PET             PET/CT
Ultrasound             Mammo                DXA          Interventional Radiology
Is requested study routine (imaging and/or biopsy)?             ☐ Yes            ☐ No
How often are patients to be imaged and/or biopsied (frequency): _________________________________
Who supplies the tracer (PET):          MGUH         Sponsor       Not Applicable
Who supplies the contrast (CT/MRI/US):          MGUH         Sponsor   Not Applicable
Are phantom scans required?            ☐ Yes (How many? ____)   ☐ No
Is additional technologist time/training required?           ☐ Yes           ☐ No       Number of Hours: ______
Professional services – do you need additional radiologist services in addition to routine interpretation?                ☐ Yes            ☐ No

Data/Imaging Transfer Information

Image storage requested:           ☐ PACS       Disc              ☐ Other _____________
Is an image transfer being requested?          ☐ Yes   (Who is responsible for image transfer?________________)             ☐ No

Contact person completing form     PI Signature

For Radiology Internal Use Only

Radiology Notes:
Will the procedures requested require additional scan/tech time?     ☐ Yes ☐ No
Will this study require special sequences or the creation of a new protocol?     ☐ Yes ☐ No
Will this study require training for techs or MDs? ☐ Yes ☐ No
Does the study require phantom scans? ☐ Yes ☐ No
Does the study require the purchase of non-standard items (e.g. isotope, contrast)? ☐ Yes ☐ No
Comments: _____________________________________________________________________________________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________

Radiology Research Vice Chair:                  Radiology Modality Reviewer:

Signature  Date               Signature  Date

Please submit research protocol, imaging acquisition guidelines, IRB approval and this form to:
GUH-RadiologyResearch@gunet.georgetown.edu