Montefiore RADIOLOGY

Radiology Research Study Form

PI Name: _____

Study Coordinator Name: _____

Research Study Title: _____

Imaging Modality:

☐ **CT** ☐**MRI** ☐**Ultrasound** ☐**PET/CT** ☐**X-Ray** ☐**NucMed**

Imaging site: _____

Has a Radiologist reviewed the imaging protocol and agreed to serve as the local Coordinating Radiologist?

☐ **Yes** ☐ **No**

If yes, who? _____

Does the research study require a clinical read?

☐ **Yes** ☐ **No**

How many cases are anticipated to enroll and over how many months?

_____

Who is paying for the scans?

☐ **Patient Insurance** ☐ **Research Study**

Note: If scans will be covered by research study please email budget details to Parina Shah at parishah@montefiore.org

Do the Sponsor/Study team need de-identified images?

☐ **Yes** ☐ **No**

If yes, please list the type of images requested (e.g.: X-rays, CT scans, etc.)

_____

PI signature: _____ **Date:** _____

Following section needs to be filled out by Coordinating Radiologist

Is the protocol different from a routine SOC scanning?

☐ **Yes** ☐ **No**

If yes, answer following questions:

Does it require to be reviewed by the Radiation safety committee?

☐ **Yes** ☐ **No**

Has it been discussed with the site manager and saved on the scanner?

☐ **Yes** ☐ **No**

Has it been approved by your Division Chief?

☐ **Yes** ☐ **No**

Radiologist Signature: _____ Date: _____

Note: Moving forward Radiology department will not schedule research patients for any clinical trials unless this from is filled out and submitted to Parina Shah. Please fill feel free to contact her @ parishah@montefiore.org or 718-920-6267 for any concern/questions.