# Research Request for Radiology Services

Office of Research and Education

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| **Study Name:** |  | |
| **Short study name:** | | |
| **ORA Tracking #:** | | |
| **Projected # of subjects at this site:** | | |
| **Projected Start Date:** | | |
| **Projected End Date:** | | |
| **Is the study being coordinated via Spectrum Health research department? If no, name organization:** | | Yes  No |

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| **Principal Investigator Name:** | |
| **Main Contact Person:** | |
| **Phone:** | **Email:** |
| **Provide a clear synopsis of specific impact on radiology services:**  **The following questions are to help determine that which is routine care and that which is not. Any questions answered “yes" may be outside routine care and need clarification with research finance, a radiologist, or the modality point person (i.e. CT, MRI, US). The results are to be reflected on the Coverage Analysis as applicable.**  Will de-identified copies of imaging be required? Yes  No  Will there be re-reads required for any imaging previously performed?Yes  No  Are all interpretations required to be performed by the same radiologist? Yes  No  Does the protocol require interpretation by RECIST or any other specific criteria not routinely used at Spectrum Health? Yes  No  Is the frequency of imaging outside of routine care? Yes  No  Are there technicalities to the protocol-imaging that are outside of what is standardly performed by the radiology department? Yes  No Unknown  Will any follow-up imaging need to be performed on the same scanner or camera? Yes  No | | |
| **If “yes” to any of the above questions, provide details of the plan** (i.e. funding arrangements/notification process for Radiology and ARS if a research patient charge is generated due to the protocol)**:** | | |
| **Provide CPT Code for each scan (must align with the Coverage Analysis):** | | |
| **All scans done for research purposes (non-routine) will be invoiced to Spectrum Health Research and all routine scans will be invoiced to the patient.**  **If this is not the case for your study, please explain:** | | |
| **What is the funding source of scans done for research purposes (non-routine)?** | | |
| **Do you have Spectrum Health IRB Approval?**  Yes, IRB # is  No, Pending | | |

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| Send the protocol with this request form to: | Send the protocol with this request form to: |
| Spectrum Health Radiology Department  Attn: Jack VanOss  [Jack.VanOss@spectrumhealth.org](mailto:Jack.VanOss@spectrumhealth.org) | Advanced Radiology Services (ARS)  Attn: Erin Ross  [eross@starsadmin.com](mailto:eross@starsadmin.com) |

*For Radiology Purposes Only:*

*Scheduling requirements: Specific site/scanner/camera? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Put in scheduling comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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| Reviewed and Approved by Spectrum Health Radiology Research Committee? If yes, date of approval: | Yes | No |
| Reviewed and Approved by ARS Research & Education Subcommittee? If yes, date of approval: | Yes | No |
| Reviewed and Approved by ARS Board of Directors, if necessary? If yes, date of approval: N/A | Yes | No |