Request for Radiology Department Collaboration for Research

Investigator ______________________________________ Department ____________________________________

Title of Project ____

Contact Person (Coordinator) _______________________________ Phone Number: __________________________

Approximate Start Date ________________ Duration: __________________ Expected Enrollment: _________________

#1 For Investigator:

This study will use radiologist professional services only (i.e. clinical standard of care)

☐ Yes — **If YES please skip to #3**

☐ No — **If NO Please indicate participating Radiologist**

Radiologist agreeing to participate:____ (signature required below)

#2 For Radiologist:

This study requires the following support (check all that apply):

☐ X-ray	☐ Fluoroscopy	☐ CT	☐ Ultrasound
☐ PET	☐ PET/CT	☐ Nuclear Medicine	☐ MRI
☐ Mammography	☐ DEXA	☐ Interventional Radiology	

Special image protocol required? ☐ Yes ☐ No

If yes, please attach imaging protocol to this form and post in respective clinical area

#3 For Radiology Administrator:

Are grant, contract, etc funds available to defray expenses of any additional services?	☐ Yes	☐ No
Will extra staffing be required:	☐ Yes	☐ No
Will services significantly impact upon regular services:	☐ Yes	☐ No
Has AUR administrator been notified to assess professional services fee(s)?	☐ Yes	☐ No

How will billing be handled?

Service Required:	**Responsible Party:**	**Billing Method:**	**Agreed upon Technical Charge:**
1.			
2.			
3.			
4.			
5.			

Investigator Signature: ____________________________________ ____________________

Radiologist Signature (if necessary): ____________________________________ ____________________

Radiology Administration Signature: ____________________________________ ____________________

Date

Please send a completed copy of this form to the Director of Research, Department of Radiology

Note: This form must be submitted as part of the investigator's IRB application for research