

**DEPARTMENT OF RADIOLOGY**  
**Questionnaire for Research Procedures**

1. Date of Application \_\_\_\_\_
2. Principal Investigator \_\_\_\_\_ Department \_\_\_\_\_
3. Academic Title \_\_\_\_\_ Phone # \_\_\_\_\_ Pager # \_\_\_\_\_
4. Title of project \_\_\_\_\_  
 \_\_\_\_\_
5. Number and type of procedures requested \_\_\_\_\_  
 \_\_\_\_\_
6. Duration of study: Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_
7. Is a radiologist a co-investigator? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If so, who \_\_\_\_\_ If not have you discussed the project  
 with a radiologist? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, who \_\_\_\_\_
8. Is this a preclinical trial? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Has requesting department negotiated hospital charges with Financial  
 Management? Yes \_\_\_\_\_ No \_\_\_\_\_

\* **IF SO, ATTACH A LETTER FROM FINANCIAL MANAGEMENT DETAILING ARRANGEMENTS.**

10. Will the patient be charged? Yes \_\_\_\_\_ No \_\_\_\_\_
11. What is the funding for this project? \_\_\_\_\_  
 \_\_\_\_\_ CRC Protocol # if applicable \_\_\_\_\_

Account to be charged:

CORP	FUND	ORG	DEPT	SUBDEPT	GRANT/PROGRAM	INST ACCT	ORG ACCT	DEPT ACCT	FN	COST CTR

12. Human Subjects approval has been received? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_
13. Animal Review Committee approval received? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

**DESCRIPTION OF RESEARCH STUDY**

**Please provide a brief (1-2 pages) description of the research project.**

RESEARCH PROTOCOL

Documentation and Charging

A gold Radiology requisition form must be provided:

1. Who in your department will be responsible for putting the patient's visit in the Informm System? \_\_\_\_\_
2. For CT or MRI scans, has SCANNING Protocol been completed? Yes\_\_\_\_ No\_\_\_\_  
(A copy of the scanning protocol must be attached to the A1A requisition.)
3. Will medical supplies be needed that will be provided by radiology (Catheters, contrast media, etc)? Yes\_\_\_\_\_ No\_\_\_\_\_  
If so what \_\_\_\_\_  
\_\_\_\_\_
4. If your patient requires sedation, additional charges such as nurses charges, monitor, drugs may be incurred. (Will the grant pay these charges? Yes\_\_\_ No\_\_\_ **If not the patient will be charged.**)

**FOR PROCEDURES DONE AFTER HOURS, TECHNOLOGISTS ARE AVAILABLE ON A VOLUNTARY BASIS AND WILL BE PAID BY YOU AT 1 1/2 TIMES REGULAR HOURLY RATE. EXTRA COMPENSATION VOUCHERS WILL BE INITIATED BY THE DEPARTMENT OF RADIOLOGY. UNIVERSITY PAYROLL REQUIRES PREAPPROVAL BASED ON AN ESTIMATE OF THE NUMBER OF HOURS REQUIRED. PLEASE SCHEDULE YOUR PROCEDURE IN ADVANCE TO ACCOMPLISH THIS REQUIRED PREAPPROVAL.**

Film Routing

1. Are films to be provided? Yes\_\_\_\_\_ No \_\_\_\_\_
2. Films to be routed:  
\_\_\_\_\_ To MFE in insert  
\_\_\_\_\_ To research, never to MFE
3. Are copies needed? Yes\_\_\_\_\_ No \_\_\_\_\_  
If yes, where do copies go?\_\_\_\_\_
4. Are DAT tapes or optical discs needed? Yes \_\_\_\_\_ **Must be provided by**  
No \_\_\_\_\_ **the researcher**

**A hospital charge and professional component will be established by Financial Management and the Department of Radiology.**

**FOR ADMINISTRATIVE USE ONLY**

Procedure Name \_\_\_\_\_

Earnings Class \_\_\_\_\_

Procedure Code \_\_\_\_\_ or Specific Research Procedure Code \_\_\_\_\_

Hospital Charge \_\_\_\_\_

Professional Component \_\_\_\_\_

CPT-IV Code \_\_\_\_\_

FOR HUMAN SUBJECTS ONLY

Dictation

1. Would you like the radiologist to render an exam interpretation that would be incorporated into the patient's medical record?

Yes \_\_\_\_\_ No \_\_\_\_\_

**\* IF NO, PROCEDURE MAY NOT BE PERFORMED UNTIL MEMO HAS BEEN COMPLETED. A COPY OF DICTATION/CHARGE MEMO IS TO BE ATTACHED TO EVERY RESEARCH A1A.**

Patient Preparation

If you know the patient may require sedation, arrangements must be made at the time of schedule.

1. Patient preparation needed? (i.e. NPO, contrast, etc.)

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Clothing change? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, where? \_\_\_\_\_

3. Clinic where patient reports prior to Radiology? \_\_\_\_\_

Phone # \_\_\_\_\_ Contact person \_\_\_\_\_

4. If radiographic screening prior to MRI exam (for metallic devices) is required, will your account pay for this exam? Yes \_\_\_\_\_ No \_\_\_\_\_

**If no the patient will be charged.**

5. Will Radiology Reception be needed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, have they been informed Yes \_\_\_\_\_ No \_\_\_\_\_

6. Will patient need other exams the day of research? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what and where? \_\_\_\_\_

7. Where does patient report after Radiology procedure? \_\_\_\_\_

Other considerations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_