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| **Instructions:** |
| * **To Edit form, go to the “View” tab, then select “Edit”** |
| * **Complete the entire form and submit form to** [**radiology-research@nyp.org**](mailto:radiology-research@nyp.org) **and** [**radiology-research@cumc.columbia.edu**](mailto:radiology-research@cumc.columbia.edu) |
| * Provide a copy of protocol, research plan and imaging manual with this submission. **Identify the protocol page numbers pertaining to the Radiology procedures** |

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| **Principal Investigator** | |  | | **Phone:** |  |
| **Fax:** |  | **Email:** |  | | |
| **Coordinator** | |  | | **Phone:** |  |
| **Fax:** |  | **Email:** |  | | |
| **Financial Administrator** | |  | | **Phone:** |  |
| **Fax:** |  | **Email:** |  | | |

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| **Study Title** |  | | | | | | | | | | |
| **Department initiating Study** | | | | |  | | | | | | |
| **NIH or Industry** | |  | | | | **Sponsor name** | | |  | | |
| **Estimated number of subjects to be enrolled in study** | | | | | | | | |  | | |
| **Estimated frequency of subject scanning** | | | | | | | |  | | | |
| **Estimated start date** | | |  | | | | **Estimated end date** | | |  | |
| **IRB# *(if not available provide to Radiology when obtained)*** | | | |  | | | **Clinical Study Trial # (NCT # on clinicalstrial.gov)** | | | |  |

**Please choose all that are required:**

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| **Procedure** | **Contrast** | | **CPT Code(s)** | **Location** | **Costs** | | |
| Procedure | | | CPT | Location | NYP Technical | CUMC Professional | CUMC 168thSt & 51st St |
| **CT**  51st street  168th street | | | | | | | |
| CT Orbits | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT Face | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT Head/ Brain | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| Neck | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT Chest | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT Abdomen | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT Abd & Pelvis | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT Pelvis | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT upper extremity | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| CT lower extremity | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| Procedure | | | CPT | Location | NYP Technical | CUMC Professional | CUMC 168thSt & 51st St |
| Cervical spine | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| Thoracic spine | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| Lumbar spine | W W’OW/W’O | |  | NYP CUMC |  |  |  |
|  | W W’OW/W’O | |  | NYP CUMC |  |  |  |
|  | W W’OW/W’O | |  | NYP CUMC |  |  |  |
| **NUCLEAR MEDICINE and BONE DENSITY** | | | | | | | |
| Procedure | | | CPT | Location | NYP Technical | CUMC Professional | CUMC 168thSt & 51st St |
| Whole Body Bone Scan | | |  | NYP |  |  |  |
| MUGA | | |  | NYP |  |  |  |
|  | | |  | NYP |  |  |  |
|  | | |  | NYP |  |  |  |
| **MRI**  51st street  168th street | | | | | | | |
| Face, Neck, Orbits | W’O W/W’O | |  | NYP CUMC |  |  |  |
| MRI Brain | W’O W/W’O | |  | NYP CUMC |  |  |  |
| MRI Chest | W’O W/W’O | |  | NYP CUMC |  |  |  |
| MRI Abdomen | W’O W/W’O | |  | NYP CUMC |  |  |  |
| MRI Pelvis | W’O W/W’O | |  | NYP CUMC |  |  |  |
|  | W’OW/W’O | |  | NYP CUMC |  |  |  |
|  | W’OW/W’O | |  | NYP CUMC |  |  |  |
| MRI Breast | W’O W/W’O | |  | NYP |  |  |  |
| **X-RAYS** | | | | | | | |
|  | 1 view | 2 view | CPT | Location | NYP Technical | CUMC Professional | CUMC 168thSt & 51st St |
| Chest |  |  |  | NYP |  |  |  |
| Skeletal survey |  |  |  | NYP |  |  |  |
|  |  |  |  | NYP |  |  |  |
| **ULTRASOUND** | | | | | | | | |
| Abdomen | | complete | limited |  | NYP |  |  |  |
| Breast | |  |  | | NYP |  |  |  |
|  | |  |  |  | NYP |  |  |  |
| **PET Scan and PET/CT** | | | | | | | |
| Procedure | | | CPT | Location | NYP Technical | CUMC Professional | CUMC PET Center 168thSt |
| FDG, if required, per dose | | |  | CUMC |  |  |  |
| Other tracer: | | |  | CUMC |  |  |  |
| Brain PET | | |  | CUMC |  |  |  |
| PET Whole Body Scan (head to toe) NOT SUITABLE FOR RECIST | | |  | CUMC |  |  |  |
| PET/CT Skull to mid-thigh NOT SUITABLE FOR RECIST | | |  | CUMC |  |  |  |
|  | | |  | CUMC |  |  |  |
|  | | |  | CUMC |  |  |  |
| **BIOPSY AND GUIDANCE**  51st street  168th street NYP | | | | | | | |
| Procedure | | | CPT | Location | NYP Technical | CUMC Professional | CUMC 51st Street |
| CT guidance | | |  | **NYP** |  |  |  |
| US guidance | | |  | **NYP** |  |  |  |
| Biopsy, location may vary (eg liver) | | |  | **NYP** |  |  |  |
| Renal biopsy | | |  | **NYP** |  |  |  |
| Lung biopsy | | |  | **NYP** |  |  | **Not performed** |
| Lymph node –core needle or excisional LN biopsy | | |  | **NYP** |  |  |  |
|  | | |  | NYP |  |  |  |
| **PHANTOM SCANS and SET-UP SCANS**  **Notes: Phantom test scans: the sponsor must provide the phantom object and the cost of the exam will be charged.**  **•Phantom Scan Protocol is required for review.**  Phantom Scan ☐ Frequency \_\_\_\_\_\_\_  Special Calibrated Device (Phantom) ☐ Frequency  Human Volunteer ☐ **Set –up  (baseline)** | | | | | **Please Note:**  **•Human Volunteer scans: The cost of the exam will be charged if imaging is performed on a volunteer.**  **•Test scans on human volunteers require that the volunteer be consented under the study protocol.** | | |
| **TUMOR ASSESSMENT READS** | | RECISTCHESSON  OTHER | | |  | | |
| **Data Transmission/ Transfer Cost** | | de-identified CDs / FTP transfers | | |  | | |

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| **Further Instructions and Notes from Dept. of Radiology Note not all may be required for your study** |
| **For NIH / Foundation studies that require RASCAL-PT approval from Radiology**   * At the time of Cost Estimate submission and Initial Budget review: * for CUMC Radiology Dept approval - please add Rae Vagg * for NYP Radiology Dept approval – please add Kate Spaziani |
| **Prior to the start of the study:**   * One month prior to first subject scan For NYP/ CHONY/ CUMC location scans: * Email Directors/ contacts of the Radiological Centers for a Start-up meeting:   IRB #, PI name, (updated) approved Protocol, Imaging guidelines / manual, IRB approval, JRSC packet and approval, chart string |
| * Note: following the review of the imaging guidelines and protocol, a Research Protocol has to be built into the scanner by the Radiologist, hence the request for imaging protocol 1 month prior to first subject scan. |

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| **PI Signature** |  | **Date Signed** |  |
| **Date submitted** |  | | |