NewYork-Presbyterian
Columbia University Medical Center

COLUMBIA UNIVERSITY MEDICAL CENTER

RADIOLOGY RESEARCH COST ESTIMATE REQUEST FORM

☐ Complete entire form and a cost estimate will be reviewed and responded to within 48 hours (business days). Submit the completed form to: radiology-research@nyp.org *and* radiology-research@cumc.columbia.edu *(include Rae Vagg as RASCAL sign off).*

☐ Provide either a copy of the **protocol/research plan/imaging manual** with this submission. Identify the page numbers that pertain to Radiology: _____

☐ Date Submitted: _____

Study Title: _____

_____

Department Initiating Study:_____

Sponsor Source: (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#** _____

Contact Information:

Principal Investigator: _____ Phone: _____

Fax: _____ E-mail: _____

Coordinator Name: _____ Phone: _____

Fax: _____ E-mail: _____

Administrator (Financial Contact) Name: _____ Phone: _____

Fax: _____ E-mail: _____

Imaging Protocol Setup and Q/A:

Will a setup scan(s), be required? (Y/N) _____

Will a control run be require phantom Q/A for the study? (Y/N) _____, if yes, please describe the control run_____

Are routine QA phantom scans required? (Y/N) _____ How often? _____

Will de-identified CDs be required? (Y/N) _____

Will secure FTP transfers be required? (Y/N) _____ } Will these be in batch or real time? _____

Will there be any contrast/radiopharmaceutical needed? (Y/N)_____If yes, please include type and dose per procedure in grid below.

- **Imaging, in addition to the routine standard of care (routine clinical services), should be listed separately. For example, any 3D imaging, data processing, or data reconstruction, etc.**
- **Locations: CUMC Radiology –MRI Research Center, PET Center, CUMC 51st Street, and NYP. The location of the study will be indicated below by Radiology, based on the equipment capability and available.**

	Imaging Study #1	Imaging Study #2	Imaging Study #3
Modality			
Procedure			
Contrast (Name and Dose)			
Description			

Will there be pre/post procedural documentation required by the imaging technologist or modality (DTF)? (Y/N)_____, If yes, please attach the document to be filled out. Please note, documentation requirement will incur a research time charge.

Notes:

1. **All studies performed at NYP must be scheduled through Radiology Access Center (212) 305-9335.**
2. **All patients must arrive with a grant slip, clearly noting financial class and IRB number.**
3. **PI is responsible for imaging fees. If a claim is denied, the fee will be charged to PI via Blue Bill.**
4. **Optimally, coordinators should arrive with patient to ensure expedited service.**

I agree that I have reviewed this submission. To the best of my knowledge and belief the information to be true, correct and complete. In addition, if discrepancies are identified at a later point, I agree to collaborate with all parties involved to the point of resolution.

_____ _____ , _____

Signature (Principal Investigator) Print Name Date

TO BE COMPLETED BY RADIOLOGY

Study Title/IRB#: _____

	Imaging Study #1	Imaging Study #2	Imaging Study #3
Modality			
Procedure			
Procedure CPT			
Contrast			
Contrast CPT			
Phantom			
Q/A			
Data Transmission/Transfer Cost			
Other			
Price Professional/CU			
Price Global/CU			
Price Technical/NYP			
Total			
Location			