



Coastal HSDA Radiology Department Resource Utilization

PROTOCOL #: _____

TITLE OF STUDY:

Principal Investigator: _____ Research Department: _____
Study Coordinator: _____ Telephone: _____
Fax: _____ Pager: _____ E-mail: _____

BILLING CONTACT INFORMATION:

Study Sponsor: _____
Invoices are to be sent to: _____
Address: _____
Phone: _____ Fax: _____ E-mail: _____

Contact in Radiology: _____

PROTOCOL:

Imaging procedure required:

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Start date of study: _____ Anticipated end date of study (if known): _____

Total number of subjects/participants in the study: _____

Number of follow-ups and frequency: _____

Length of Study: _____

Which images require a diagnostic report? _____

Is a specific Radiologist required to report and which images? _____

Which images require a copy on CD? _____

Manager Approval (Signature): _____ Date: _____