Integrated Medical Imaging
Research Requirement Form

Integrated Medical Imaging
VCH Corporate Office
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Protocol #:			
Title of Study:			
Name of Principal Investigator:	**Research Department:**		
Name of Study Coordinator:	**Phone:**	**Email:**	
Billing Contact Info: **Name:**	**Address:**	**Phone:**	**Email:**
Is this study MSP Billable?	**Yes** ☐	**No** ☐	
Do you require Phantom scan before site being approved for the study? **Please indicate if required before each exam*	**Yes** ☐	**No** ☐	
Do you require a sample scan before site being approved for the study? **Please indicate if required before each exam*	**Yes** ☐	**No** ☐	
Do you require specific Imaging exam parameters for this study?	**Yes** ☐ **Please provide Imaging manual**	**No** ☐	

Please list Medical Imaging exam/study required under appropriate modality:

CT: 1. 2. 3. ***contrast required?***	**MRI:** 1. 2. 3. ***contrast required?***	**Ultrasound:** 1. 2. 3.	**General Radiology:** 1. 2. 3.
Nuclear Medicine : 1. 2. 3.	**Interventional:** 1. 2. 3.		
Start date of study:	**Anticipated end date of study (if known):**	**Total # of subjects/participants in the study:**	**Number of follow-ups & frequency:**
Length of study:	**Which images require a diagnostic report?**	**Which images require a copy on CD?**	**Which images require anonymized or blinded?**

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