

Integrated Medical Imaging Research Requirement Form

Integrated Medical Imaging
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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:
Contact in Medical Imaging:			
Is this study MSP Billable?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you require Phantom scan before site being approved for the study?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you require a sample scan before site being approved for the study?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you require specific Imaging exam parameters for this study?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Please list Medical Imaging exam/study required under appropriate modality:			
<u>CT:</u> 1. 2. 3.	<u>MRI:</u> 1. 2. 3.	<u>Ultrasound:</u> 1. 2. 3.	<u>General Radiology:</u> 1. 2. 3.
<u>Nuclear Medicine :</u> 1. 2. 3.	<u>Interventional:</u> 1. 2. 3.	<u>GI/GU:</u> 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?

