DEPARTMENT OF RADIOLOGY AND IMAGING SCIENCES
INDIANA UNIVERSITY
School of Medicine

Research Imaging Registration Form

I. General Study Information

Study Title: _____

Protocol Number: _____ IRB Number: _____ Start/End Dates: _____

Funding: _____ Sponsor: _____ Department: _____

PI Name: _____ Phone: _____ Email: _____

Study Contact Name: _____ Phone: _____ Email: _____

Study Location(s): _____

II. Imaging Services

☐ CT ☐ MRI ☐ PET/CT ☐ Nuclear Medicine ☐ Ultrasound ☐ X-ray ☐ Mammogram ☐ DXA ☐ IR/Fluroscopy

PROCEDURE/SCAN DESCRIPTION (Ex. Chest CT with contrast, FDG PET-CT, MRI Abdomen w/ contrast)	Number per Year for [a]Research	Number Over Entire Study for [a]Research	Number per Year for [b]SOC	Number Over Entire Study for [b]SOC

☐ Please check this box if the ONLY research scans required by the study protocol are at screening and considered 'outside of window.' (You are still required to list those in the table above).

***a.** Research: This is the number of the listed procedures or scans that are only performed because the subject is participating in this research study and would not be performed as part of the subjects' standard care. Research procedures/scans may include some baseline, screening, optional, out of window, biopsy and progression scans. Please consult the PI to determine what scans/procedures are performed for research purposes only.
***b.** SOC: Standard of Care. This is number of procedures or scans performed as part of the subjects diagnostic treatment process independent of participation in this research study.

III. Study Startup Information

Will an IU Radiology faculty member receive budgeted effort from this study? _____

Number of Patients for entire study: _____

Total number of subjects under 18 years of age, if any: _____

Are women of child bearing age to be included in this this study? _____

Are any subjects "healthy" volunteers? _____

How many days are in each cycle? (if applicable): _____

Will anonymized image data be sent to a Core Lab for this study? _____ If yes, name: _____

Has an IU Radiologist or Imaging Scientist reviewed this protocol? If so, who? _____

Please mark all of the study specific research services required by the study from Radiology:

- ☐ Site Questionnaire
- ☐ Site Initiation Visit
- ☐ Budget Quote
- ☐ Radiation Safety Dosimetry/ Application
- ☐ Study Specific Research Scan Protocol
- ☐ Phantom Scans
- ☐ Technologist / Radiologist Training
- ☐ Data Anonymization & Transfer to Sponsor/Core Lab
- ☐ Image Data Form Completion
- ☐ Query Resolution
- ☐ Data Storage
- ☐ Specialty Read/Measurement (i.e. RECIST)

Special Instructions

IV. Attestation

PI Signature

The information provided in this form is correct and complete to the best of my knowledge. Any study addendum that would change the information in this form will be provided to Radiology as it is received. In lieu of a digital signature, by placing an "X" in the box below, the individual completing this form verifies that the information contained in this application has been shared with the PI and the PI is in full agreement with the contents of this registration form.

☐ I hereby verify that the contents of this application have been shared with the applicant and the applicant is in full agreement with the information contained herein.

Name of individual providing this verification

Date

*Please submit this form and study protocol to ori@iupui.edu. IUSOM Radiology research services will be billed by IU Radiology and Imaging Sciences. Imaging services at IU Health will be billed by the IU Health Revenue Cycle Services.