



**DEPARTMENT OF NUCLEAR MEDICINE AND CENTRE FOR PET
RESEARCH CLINICAL TRIALS PROTOCOL FORM
NUCLEAR MEDICINE DEPARTMENT-**

DATE:		
Copy of study protocol submitted to Nuclear Medicine:	<u>Yes</u>	<u>No</u>
Trial Title:		
Protocol Number:		
Principal Investigator/Trial Coordinator:		
Department/Institute:		
Contact Number:		
E-mail Address:		
Pager Number:		
SPONSORSHIP/FUNDING (Please Tick)		
Pharmaceutical Company:	Yes	No
If Yes, What is their Name?		
NH&MRC:	Yes:	No
AHMRF:	Yes	No
Other: (Please Specify)		
BILLING DETAILS (Please Tick)		
Transfer of Funds?	Yes	No
Invoice to be Sent?	Yes	No
As Patient Presents?	Yes	No
Invoice Quarterly?	Yes	No
<u>TRIAL DETAILS</u>		
Number of Patients:		
Date of Trial Commencement:		
Trial Completion Date (estimate):		
Modalities: (Please Tick)	Nuc. Med	PET
	Therapy	Other
Cost per scan or	\$	
Cost per patient	\$	
Report to be forwarded to:		
Study to be performed at (please tick)	Austin	Repat
Day of the week patient to be scanned, if known?		
Signature of Principal Investigator:		
Please return this form to Ms. Morena Scalzo, Administrative Assistant, Department of Nuclear Medicine and Centre for PET Austin Health, 145 Studley Road, Heidelberg 3084 Ph: 9496 5163		
Approved by Director of Nuclear Medicine		
Date:		



Centre for Positron Emission Tomography

Austin Health

Austin Hospital, Level 1, Harold Stokes Building,

Telephone: (613) 9496 3329 or 9496 5669 Facsimile: (613) 9458 5023

RESEARCH CLINICAL TRIALS PROTOCOL FORM

Study Protocol submitted to Centre for PET and approved for PET scans

DATE:		
Copy of Study Protocol submitted to Centre for PET? (If no, please submit a copy along with this form.)	<u>Yes</u>	<u>No</u>
Study/Trial Title:		
Protocol Number:	Ethics Number/Project Number:	
Principal Investigator/ Study/Trial Coordinator:		
Department/Institute:		
Contact Numbers:		
E-mail Address:		
Pager Number:		
SPONSORSHIP/FUNDING (Please Tick)		
Pharmaceutical Company:	Yes	No
If Yes, What is their Name?		
NH&MRC:	Yes	No
AHMRP:	Yes	No
Other: (Please Specify)		
<u>STUDY/TRIAL DETAILS</u>		
Number of Patients:		
Number of Scans Per Patient:		
Date of Study/Trial Commencement:		
Study/Trial Completion Date (estimate):		
Invoice request to be forwarded to: <u>Name</u>		
<u>Address</u>		
Cost PER SCAN for FDG scans:	\$	Notes/misc:
Cost PER SCAN for non-FDG scans: Tracer/Details:	\$ (if applicable)	
Report to be forwarded to:		
Day of the week patient to be scanned, if known?		
Signature of Principal Investigator:		
Please return this form to Ms. Anna Peretta or Morena Scalzo, Administrative Assistant, Department of Nuclear Medicine and Centre for PET Austin Health, 145 Studley Road, Heidelberg 3084. Ph: 9496 5163		
APPROVALS (Centre for Positron Emission Tomography)		
_____		Date: ____ / ____ / ____
Prof Andrew M Scott, Director, Centre for PET		
_____		Date: ____ / ____ / ____
Mr Nick Alexopoulos, Manager, Department of Nuclear Medicine & Centre for PET		
_____		Date: ____ / ____ / ____
Prof Chris Rowe, Director, Department of Nuclear Medicine & Centre for PET		
Date this form returned to Principal Investigator:		