



Department of Radiology

Radiology Clinical Trials Protocol Form Austin Radiology		
Contact Details:		
Copy of study protocol submitted to Radiology? Please Tick Yes or No:	Yes	No
Trial Title:		
Protocol Number:		
Principle Investigator and Trial Coordinator:		
Site Coordinator:	MO:	Pager No:
Department/Institute:		
Contact Number:		
E-mail Address:		
Trial Details:		
Number of Patients:	Total expected no. of exams per patient =	
	Total expected number of exams =	
Date of Trial Commencement:	Trial Completion Date: (estimate)	
What imaging is required? (please tick)		
CT	MRI	US
Plain Xray	Other	
How frequent will the scans be?		
Is the imaging standard or non-standard?		
Please state if these scans are billable to the trial	Yes	No
Do images need to be de-identified?	Yes	No

Is specific reporting required (eg RECIST)?	Yes	No
Does the study require a phantom and calibration?	Yes	No
Is there a radiography manual?	Yes	No
Is anyone required to attend a start up meeting?	Yes	No
Please specify here if scans are required to be performed at particular time or day of week:	Yes	No
Do you require anything else from the Radiology Department?	Yes	No
Sponsorship/Funding Details:		
Pharmaceutical Company:	Yes	No
NH&MRC:	Yes	No
AHMRP:	Yes	No
Other (please specify):		
Billing/Invoice Details:		
Option A		
Transfer of funds from your Cost Centre Number (For internal debtors)	Cost Centre	Account No
Option B		
Invoice sent via Finance Department (cannot be invoice from one internal dept to another)	Yes	No
Option C		
Please supply name and address to appear on invoice (Only applies to external debtors)		
Signature of Principal Investigator:		
Please return this form to Jenny Hollaway, Research Administrator, Radiology Department, Level 1, Austin Hospital, Heidelberg 3084 Phone 9496 2074 Email: jennifer.hollaway@austin.org.au		
Approved by Director of Radiology:		
Date:		
Comments:		