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| Date: | Date Received by Radiology: |
| **Protocol Number:****Trial Title:** |
| What supporting documentation has been received? |
| Trial Protocol Imaging ManualOther (specify)Amendment: Radiology Reference Number |
| Department or Institute:  |
| Principal Investigator: | MOBILE No: | Pager No: |
| Site or Trial Coordinator:  | Contact No email address: |
| **TRIAL DETAILS** |
| Date of Trial Commencement | Date of Trial Completion (estimation) |
| Number of patients in the trial that require imaging at Austin Radiology: |
| Total expected no of exams per patient: | Overall total: |
| **TYPE OF IMAGING REQUIRED** (Please be specific and provide a full explanation of type of imaging required i.e. Brain, Chest/Abdomen/Pelvis etc.) |
| **Modality** | **Imaging required**(Body region) | **Frequency of Imaging** | **Would this be part of the patient’s routine clinical care? (YES/NO**) | **List ALL page references in Protocol relating to Imaging required** |
| **CT** |  |  |  |  |
| **MRI** 1.5T  3 T  |  |  |  |  |
| **Plain X-Ray** |  |  |  |  |
| **Ultrasound** |  |  |  |  |
| **Fluoroscopy** |  |  |  |  |
| **Intervention** **(e.g. Biopsy or Lumbar Puncture)** |  |  |  |  |
| **Comments:** |
| **Please complete the following for all interventional procedures:** |
| 1. **Type of procedure/ biopsy:**

 **LP  Core  FNA  TARGETED  NON-TARGETED** **Other**  |
| 1. **Type of image guidance required (e.g. CT, Ultrasound, Fluoroscopy):**

 **CT  Ultrasound  Fluoroscopy  Other (specify)** |
| 1. **Site of biopsy e.g. Lung, liver (targeted lesion or non-targeted), lymph node. Please list all sites to be targeted:**
 |
| 1. **Number of lesions to be biopsied:**
 |
| 1. **Number of samples required per lesion:**
 |
| 1. **Time course of biopsies during trial (e.g. at baseline, 2 cycles/12 weeks after start of study therapy, disease relapse, end of study). Please list all time points for biopsies:**
 |
| 1. **How many interventional procedures per patient will be required during the course of the trial?**
 |
| 1. **If a repeat biopsy is required during the trial, should the follow up biopsy be taken from the same tumour lesion as the baseline biopsy or representative site of disease progression?**

 **Yes  No ( Specify)** |
| 1. **How does the sample need to be collected?**

 **Fresh  Formalin  FNA Is cytologist attendance required?  Yes  No** **Special Instructions**  |
| 1. **Will specialist collection containers be provided?  Yes  No**

**If not, what tubes/collection containers will be required?** |
| 1. **Will a Trial Coordinator collect the sample/s? YES  NO**

**If YES- A Trial Specific Pathology Request form needs to be provided to Radiology prior to patient arrival for specimen collection.****If NO- will Radiology staff be required to send sample/s to Pathology? YES NO** |
| **Reporting Requirements**: Please specify the type of Report needed or other specifics to be included in the Radiology report: e.g. **RECIST,  ARIA** or  **Standard Report**: |
| Is anyone required to attend a start-up meeting? Yes No If yes: |  Radiologist |  Radiographer |
| Does the study require a phantom and calibration? |  YES | NO |
| Do the images need to be de-identified? |  YES | NO |
| Please specify if scans are required to be performed at a particular time or day or week:  |

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| **CLINICAL TRIAL/PROTOCOL REVIEW & SET UP FEE $600.00****Payment is required prior to or at the time of submission** |
| **Transfer of funds from your Cost Centre**  | **COST CENTRE** | **ACCOUNT NUMBER** |
| **SPONSORSHIP/ FUNDING DETAILS** |
| Pharmaceutical Company : YES NO |
|  NH& MRC: AHMRF:  Other (please specify): |
| **BILLING/INVOICE DETAILS** |
| **Option A** |
| **Transfer of funds from your Cost Centre Number** (for Internal Debtors only) | **COST CENTRE** | **ACCOUNT NUMBER** |
| **Option B** |
| **Invoice sent via Finance Department**(this cannot be an invoice from one internal Dept to another) |  NO  YES (Complete section below) |
| **Please supply the name and address you wish to appear on the invoice** (This only applies to External Debtors) | Company Name:Address:ABN:Contact Name:Ph. Number:Email address: |

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| **Signature of Principal Investigator:** Date: |
| **Please return this completed form to** **Clinical Trial Coordinator**Phone (03) 9496 3328Email: Radiologyresearch@austin.org.au | **Clinical Trial Coordinator,**Radiology Department,Level 2, Lance Townsend BuildingAustin HospitalHeidelberg Vic 3084 |
| **Approved by Acting Deputy Director of Radiology** (Medical)                                                                                                                                                                      Date: |