|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date: | | | Date Received by Radiology: | | | | | | | |
| **Protocol Number:**  **Trial Title:** | | | | | | | | | | |
| What supporting documentation has been received? | | | | | | | | | | |
| Trial Protocol  Imaging Manual  Other (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: | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **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: | |

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