

Work Flow for Radiological Services Request Forms (RSRs)

(MANDATORY)

The Department of Radiology supports and encourages clinical research at UCD Health. It is mandatory that Principal Investigators (PIs) and/or their CRCs complete and submit a Radiological Services Request (RSR) form prior to conducting research requiring Radiology support.

Within 14 days of receipt, the Radiology Research Committee (RRC) will review and provide either an Exemption or an RSR Estimate. Urgent requests will be considered. Research rates are posted: <https://health.ucdavis.edu/radiology/research/rates.html>

Please note that it is the responsibility of the Investigator or research team to obtain images from either HIM (previously film library) or PACS for de-identification and transmission to sponsors.

Once final IRB approval is received, the PI or CRC must send an email notification to the RRC at the following email address: research-radiology-som@ucdavis.edu. The RRC will make arrangements with the PI and/or CRC to schedule the study start up meeting.

Initial Submission Requirements:

- Completed RSR Form
- Protocol
- Imaging Acquisition Guidelines (if available)
- Copy of Billing Grid or MCA

Email to establish Study Startup Requirements:

- IRB approved Protocol (and Imaging Protocol, if applicable)
- RSR Estimate signed by the Department or Investigator requesting services
- RUC approval form

RRC review to determine:

- Are there research only procedures involved?
 - No; Exempt
 - Yes; RSR Estimate and Radiology requirements outlined

ALL Radiology research procedure request packets should be submitted to:

research-radiology-som@ucdavis.edu

Radiological Services Request (RSR)

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Requesting Department Information

Department Name: _____	Contact Person Email: _____
Principal Investigator: _____	Contact Person Phone #: _____
Form completed by: _____	

Project Information

Estimated project start date: _____	Estimated project end date: _____	IRB# _____
Study Title (per Protocol): _____ _____		
Protocol Number: _____		
Study sponsor: _____	Anticipated # of total patients: _____	
DAFIS/Acct to Invoice: _____		

Research procedures requested

<input type="checkbox"/> CT (# of scans per pt.): _____	<input type="checkbox"/> DEXA (# scans per pt.): _____
<input type="checkbox"/> Interventional Radiology (#scans per pt.): _____	<input type="checkbox"/> Mammography (#scans per pt.): _____
<input type="checkbox"/> MRI (#scans per pt.): _____	<input type="checkbox"/> Nuclear (#scans per pt.): _____
<input type="checkbox"/> PET (#scan per pt.): _____	<input type="checkbox"/> Ultrasound (#scans per pt.): _____
<input type="checkbox"/> Vascular Lab (#scans per pt.): _____	<input type="checkbox"/> X-Ray (#exams per pt): _____

Technical procedures requested

Is Tracer supplied by Study/Sponsor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
UCDH Radiologist Interpretation Required:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Special	<input type="checkbox"/> Dynamic	<input type="checkbox"/> RECIST
CRC Support Requested?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Special Requests/notes:	_____		

For Radiology Internal Use Only

Radiology Clinical Research Supervisor:		Radiology Imaging Reviewer:	
_____		_____	
Signature	Date	Signature	Date