# Order for IRB-Approved Research Study in Emory Radiology

**THIS FORM IS FOR ANY RESEARCH STUDY INVOLVING *IMAGING***

**IF IMAGE-GUIDED *BIOPSIES* ARE TO BE PERFORMED PLEASE USE THE REQUIRED BIOPSY FORM**

This form is used for ordering and scheduling imaging mandated by a research protocol for Outpatients ONLY. This form must be completed and **faxed to 404-778-3335** for ***non-invasive*** imaging studies prior to calling the Radiology scheduling office @ 404-778-9729 and for ***invasive procedures*** **faxed to 404-712-7122** prior to calling the Radiology scheduling office @ 404-712-0566. Incomplete forms will not be accepted.

 P.I. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Research Coordinator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Coordinator Contact (PIC or phone number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Grant Name or Acronym \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IRB # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Bill to [check one of the following]

 [ ] Grant Speed Type # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code Z00.6

**RESEARCHER**: This order is to be used only for those patients who are participating in an IRB approved study with an Emory PI. This request is only valid for the below procedures:

## Patient/Subject Name: (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Subject DOB \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT: Name of ordering physician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ordering physician signature Date signed (Required) Time signed (Required)

1. **PROCEDURES FOR RADIOLOGY IMAGING**
2. **Radiology exam(s) ordered**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[ ] No special additional images or sequences required by protocol

[ ] Special additional images or sequences required by protocol (please specify requirements below; these must be approved in advance by Dept of Radiology Vice

Chair for Research using Office of Quality approval process)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does this imaging exam have to be performed at a particular location or on a particular piece of equipment?
	1. [ ] No
	2. [ ] Yes
		1. Name of location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		2. Specific equipment name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. The radiology images are to be interpreted as follows:
	1. [ ] Normal interpretation process
	2. [ ] Interpreted only by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(this must be prearranged)
	3. [ ] There is to be no interpretation (this is indicated in the IRB approved informed consent)
3. The report is part of the Medical Record:
	* 1. [ ] Yes
		2. [ ] No (this is indicated in the IRB approved informed consent)
4. The images are to be archived in PACS (same process as for clinical images):
	* 1. [ ] Yes
		2. [ ] No
5. If images are to be put on a CD please check box here: [ ] YES