**Resource Use Application Form**

# **Research Imaging and Clinical Physiology Service**

# **includes echocardiogram, exercise ECG, ECG, MRI, VO2max and DEXA**

Hopper Crossing  Alfred Centre

|  |  |
| --- | --- |
| **Resource use application approval** | |
| Date: |  |
| **Approval – Head, Cardiometabolic Health and Exercise Physiology Lab (All services including CPET/VO2max, Dexa)** | |
| Signed: |  |
| Name: | A/Prof. Erin Howden |
| **Acknowledged Approval – Head of Cardiovascular Clinical Services (Echo, Holter, ECG, BP Monitor)** | |
| Signed: |  |
| Name: | Dr. Kegan Moneghetti |
| **Acknowledged Approval – Head, Cardiovascular MRI (MRI services)** | |
| Signed: |  |
| Name: | Dr. Sarah Gutman |
| **Acknowledged Approval - Senior MRI radiographer – (MRI services)** | |
| Signed: |  |
| Name: |  |

**Section 1: Project details**

|  |  |
| --- | --- |
| Title: |  |
| Name of HREC: |  |
| Study number: |  |
| Chief Investigator: |  |
| Research organisation: |  |
| Email: |  |
| Phone: |  |
| Expected commencement date: |  |
| Expected completion date: |  |
| Briefly describe proposal, including experimental procedure to be used (min. 25 words): | |
|  | |
|  | |

**Section 2: Payment details for service**

|  |  |
| --- | --- |
| Baker Institute studies | |
| Cost centre: |  |
| Project code: |  |
| Source of funding for this project:  (e.g. NHMRC project grant number) |  |
| External studies | |
| Name of contact for payment: |  |
| School/Centre: |  |
| Faculty/Institute: |  |
| University/Organisation: |  |
| Email: |  |
| Phone: |  |

**Section 3: Investigations**

|  |  |
| --- | --- |
| Anticipated number of study participants: |  |
| Expected duration of study: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Scans** | **No. of participants** | **Scans / tests per participants** | **Duration between scans / scans** | **Total No. of**  **scans / tests for project** | **Cost quoted by Clinical Research Department (per scan/test) incl reports** |
| 🞎 Echocardiogram |  |  | weeks/months |  |  |
| 🞎 ECG |  |  | weeks/months |  |  |
| 🞎 MRI |  |  | weeks/months |  |  |
| 🞎 CPET |  |  | weeks/months |  |  |
| 🞎 DXA |  |  | weeks/months |  |  |
| 🞎 Other – please state |  |  | weeks/months |  |  |

**Specific details for echocardiograms**

Can participants be bulk billed for their scans? **Yes / No**

**Specific details for MRI scans**

Please discuss with the Baker radiographer on duty and confirm the following. Ensure details cited are approved by the radiographer.

MRI scan time incl. time for preparation and post scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Is Imaging Protocol attached to this form? | Yes 🞎 Approval required  - Baker radiographer to sign: |
| Is an MRI WIP required? No 🞎 | Yes 🞎 Approval required    - Baker radiographer to sign: |
| Is an IV contrast required? No 🞎 | Yes 🞎 Approval required  - Baker radiographer to sign: |

NB: The study investigator must liaise with the Baker radiographer/s early to ensure that an MRI protocol (which is separate to the main study protocol) is developed and finalised **PRIOR** to the study commencing.

**Specific details for external studies — Items provided by the research organisation**

Please specify any materials or items to be supplied by the Research Organisation to enable the scans to proceed:

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| **Please list all required MRI protocols below or attach as a separate document:** |

**Section 4: Investigators**

Please specify details for each investigator who wishes to enter the scanner room. Please add extra pages if more than two investigators will be entering the scanner room.

|  |  |
| --- | --- |
| Investigator No. 1 | |
| Name: |  |
| Email: |  |
| Phone: |  |
| Investigator No. 2 | |
| Name: |  |
| Email: |  |
| Phone: |  |

**Section 5: Reporting**

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| Is there a requirement for a Report for Incidental findings (**Radiologist**)?  Yes\* 🞎 No 🞎  \*Please note this will incur an additional charge of $100 per report. |
| Is there a requirement for a Full Clinical Report (**Radiologist + Cardiologist**)  Yes\* 🞎 No 🞎  \* Please note this will incur an additional charge of $400 per report. |
| Please include the Contact Person for Report to be forwarded to below:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 6: Ethics approval**

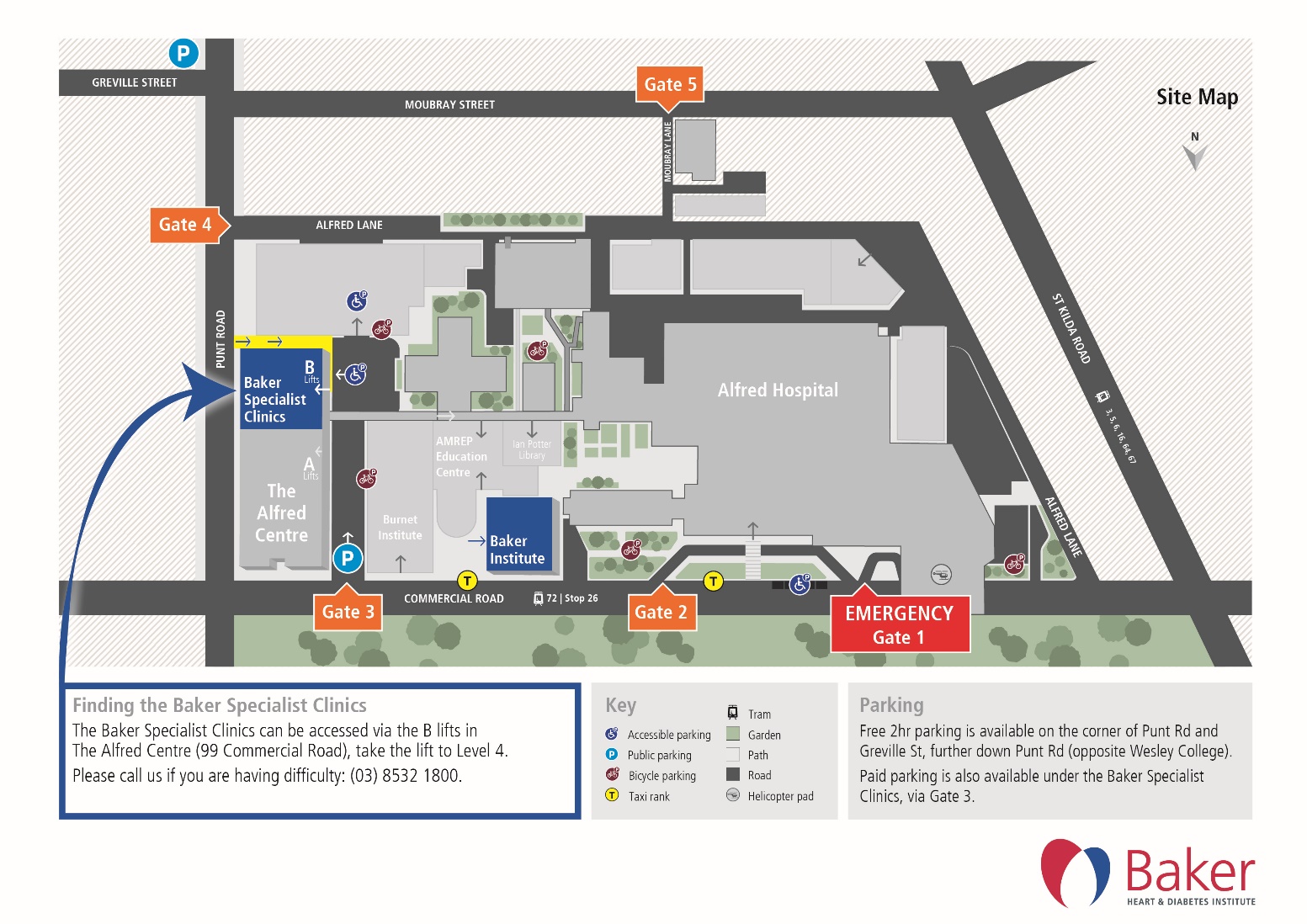
Once ethics approval is obtained, please provide:

* Copy of this form, HREC approval and **Protocol** to governance

[governance@baker.edu.au](mailto:governance@baker.edu.au)  and [contracts.manager@baker.edu.au](mailto:contracts.manager@baker.edu.au)

* Copy of this form and expected date to commence studies to Cardiometabolic Health and Exercise Physiology Lab, [Des.Fankhauser@baker.edu.au](mailto:Des.Fankhauser@baker.edu.au); **OR** if Alfred Health researcher, to Radiology Research Unit [H.Kavnoudias@alfred.org.au](mailto:H.Kavnoudias@alfred.org.au)

**Section 7: Location of the Baker Institute Research Imaging and Clinical Physiology Service**



**Version**

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| --- | --- | --- | --- | --- |
| Custodian | Created | Last review | Next review | Date of effect |
| Cardiometabolic Health and Exercise Physiology Lab | February 2018 | January 2024 | January 2025 | January 2024 |
| V3.0 – addition of incidental reporting fee |  | June 2024 | June 2025 | June 2024 |