**Resource use application form**

# **Research Imaging and Clinical Physiology Service**

# **— Includes echocardiogram, MRI, VO2max and DEXA**

|  |  |
| --- | --- |
| **Resource use application approval (office use)** | |
| Date: |  |
| **Approval – Head, Clinical Research** | |
| Signed: |  |
| Name: | A/Professor Andre La Gerche |
| **Approval – Baker Institute practitioner**  **(radiographer, sonographer, physiologist, cardiologist – as applicable)** | |
| Signed: |  |
| Name: | Mr Michael Sellenger |

Section 1: Project details

|  |  |
| --- | --- |
| Title: |  |
| Name of HREC: |  |
| Study number: |  |
| Chief Investigator: |  |
| Research organisation: |  |
| Email: |  |
| Phone: |  |
| Expected commencement date: |  |
| Expected completion date: |  |
| Brief summary of Project Services: (2 lines) | |
|  | |
|  | |

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: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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)** |
| 🞎 Transthoracic Echocardiogram |  |  | weeks/months |  |  |
| 🞎 MRI |  |  | weeks/months |  |  |
| 🞎 Vo2 Max |  |  | weeks/months |  |  |
| 🞎 DEXA |  |  | weeks/months |  |  |
| 🞎 Other – please state |  |  | weeks/months |  |  |

## Specific details for echocardiograms and DEXA

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 a 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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| --- |
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|  |
| Please list all MRI sequence algorithms to be used in the study:  |  | | --- | |  | |  | |  | |  | |

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

Is there a requirement for incidental finding to be reported?

|  |
| --- |
| No 🞎 |
| Yes 🞎  Please include the Contact Person for Incidental Finding below:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Section 6: Ethics approval

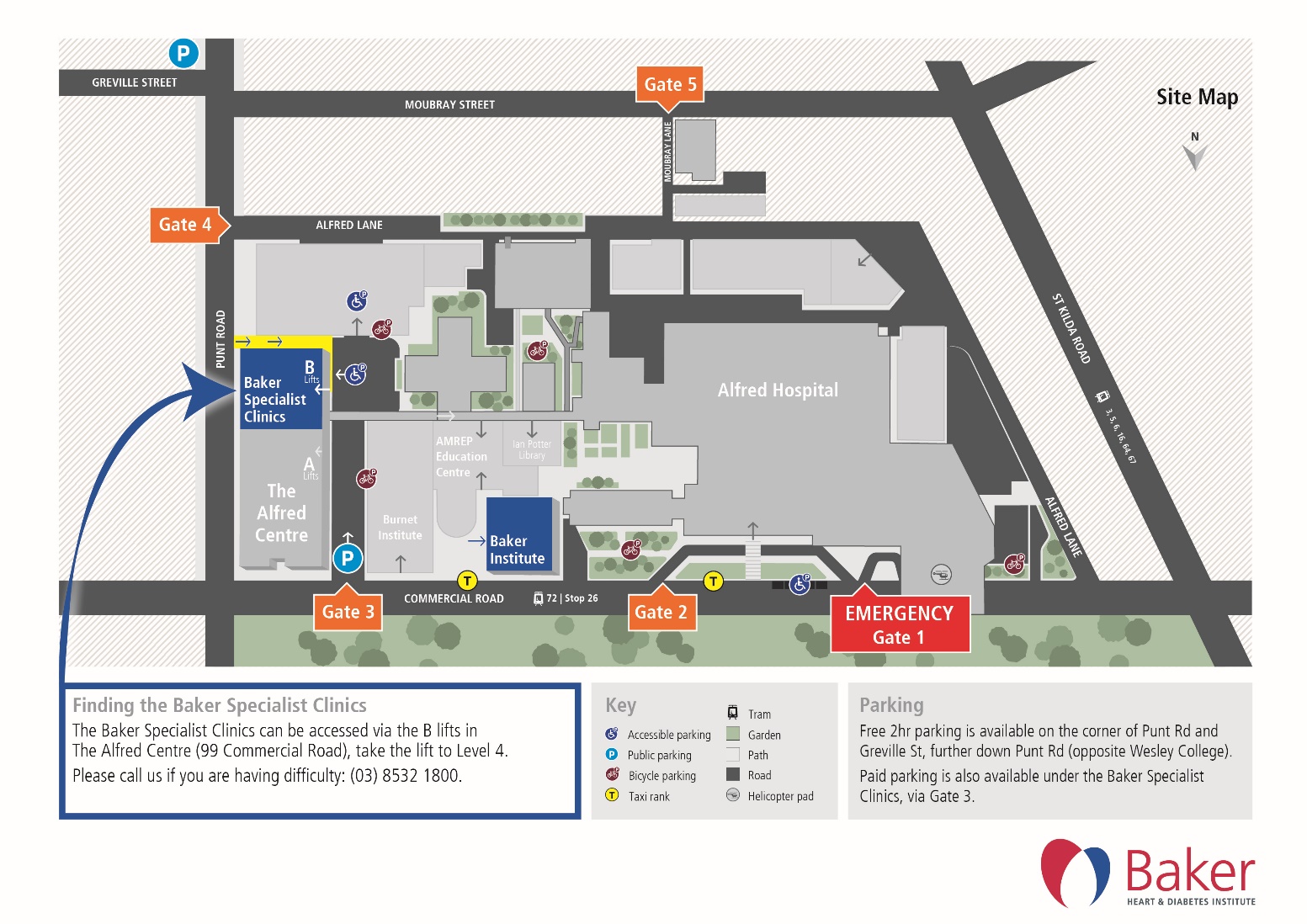
Once ethics approval is obtained, please provide:

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

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

* Copy of this form and expected date to commence studies to Clinical Research Department [saba.seifi@baker.edu.au](mailto:saba.seifi@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 |
| Clinical Research Department | February 2018 | December 2018 | December 2019 | December 2018 |