Beth Israel Deaconess Medical Center

BIDMC Translational MRI Research
New Study - Request for MR Scan Time

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Date Form Completed:

1. Project Title:

2. Short Title (5 words or less):

3. Brief Project Description:

4. Protocol # (If applicable)

IRB Protocol Number: Approval Date: Expiration Date:

IACUC Protocol Number: Approval Date: Expiration Date:

5. Anticipated Start Date: **Projected End Date:**

6. Name of the Principal Investigator

Name: Dept:

Address:

Phone: Fax:

Email:

7. Name of the Primary Contact Person e.g. responsible for running project on-site

Name: Dept:

Address:

Phone: Fax:

Email:

Cell phone for emergency contact (e.g. scanner is down, snow storm, etc.):

8. Please check one:

☐ **Funded Research Project** ☐ **Unfunded Pilot Study**

For Pilot Projects Only (obtaining data with subjects for future funded projects):

Number of hours of MR scan time requested for pilot study (20 hours max.):

If data is to be used for a grant application, please provide potential funding source and application deadline:

Date email request sent to mfox2@bidmc.harvard.edu and dalsop@bidmc.harvard.edu:

Note: Pilot projects **must be** approved in writing before completing this form. If you exceed approved hours, you must reapply for additional hours. Please contact MRI Research at MRIResearch@bidmc.harvard.edu with any questions.

For ALL Funded Accounts:

Source (e.g. NIH, etc) of Funding:

Duration of Funding: Start Date: End Date:

Billing Information:

Research Administrator: Phone:

Address: Email:

Established studies: BIDMC Account Number:

Please provide the names and email addresses for who the invoice should be sent to (i.e. PI, CRA, Research Administrator, etc.):

Was study derived from BI Pilot MR data? ☐ Yes ☐ No

Is Pre-Protocol Development Required--setting up the protocol/sequences with the technologist on the scanner?

☐ Yes ☐ No

Number of hours requested for protocol development (should not exceed 5 hours):

Name of person you are working with from MRI Research re: protocol development, if applicable:

If protocol is known, please list sequences:

9. Which magnet will be used:

☐ **1.5T** ☐ **3T** ☐ **Both 1.5T and 3T** ☐ **West Campus MRI**

10. Estimated duration and total number of scanning sessions requested.

*Reminder, a standard study slot consists of a 45 minute scan and 15 minutes for setup, breakdown, and cleaning. Please also include the time to set up study equipment. Studies will be booked and charged in 30 minute increments. The time may be adjusted accordingly after the pre-protocol phase is complete. Please contact Fotini Papadopoulou, MRI Research Technologist, with questions related to scan duration @ 617-667-2156 or email fpapadop@bidmc.harvard.edu

Total number of subjects:

Total number of scans/subject:

Estimated scan time/subject:

11. Will contrast be used?: ☐ **No** ☐ **Yes**
If yes, please submit the approved Part E.

Type, dose & route:
Administered by ☐ **prior to scan** ☐ **during scan**

Type, dose & route:
Administered by ☐ **prior to scan** ☐ **during scan**

12. Will medications other than contrast be administered prior to the scan or during the scan?: ☐ **No** ☐ **Yes**

Type, dose & route:
Administered by ☐ **prior to scan** ☐ **during scan**

Type, dose & route:
Administered by ☐ **prior to scan** ☐ **during scan**

Type, dose & route:
Administered by ☐ **prior to scan** ☐ **during scan**

13. Will healthy volunteers be scanned? ☐ **Yes** ☐ **No**

Number of healthy volunteers to be scanned:

Frequency of scan(s) per healthy volunteer and interval:

14. Will patients be scanned? ☐ **Yes** ☐ **No**

Number of patients to be scanned:

Frequency of scan(s) per patient and interval:

Are there clinical scans that need to be booked in CCC and charged to the patient's insurance? ☐ Yes ☐ No

Will your study use LAR's to obtain consent? ☐ Yes ☐ No
If yes, will the LAR/a family member familiar with the patient's medical history be able to accompany them to the MRI to complete and review the MRI Safety Form? ☐ Yes ☐ No

15. Will animals be used in this study: ☐ Yes ☐ No
If yes, please describe the details of the study in an attached document or email to MRIResearch@bidmc.harvard.edu
What is your IACUC approval number: IACUC Approval Date: IACUC Expiration Date:

16. Will hazardous chemicals, inhalational anesthetics, or infectious agents be used in this study? ☐ Yes ☐ No
If yes, please describe the details of the study in an attached document or email to MRIResearch@bidmc.harvard.edu

17. Will you be bringing any objects or devices that will need to enter the MRI Room during this study? ☐ Yes ☐ No
If yes, please send the of the object/device in an attached document or email to MRIResearch@bidmc.harvard.edu

18. Will you be using the Nova Head Coil or any other non-FDA approved devices during the MRI Scan? ☐ Yes ☐ No
If yes, please submit the approved Part G and name the device and its purpose:

I attest the information provided in this application is current and accurate. I will adhere to the BIDMC policies as stated in the Ansin Research scanners, MRI Policy and Procedures and ensure finance responsibility for the cost of the study.

Printed Name of Principal Investigator: Date:
(Electronic Signature)

Checklist for Submission

- ☐ Completed Requisition for MR Scan Time (submit e-version with electronic signature)
- ☐ Research Protocol (Part B of BI IRB application is sufficient), Part A, and Research Staffing Form
- ☐ Current "IRB Approved" consent form (electronic PDF preferred)
- ☐ IRB approval letter from "home" institution (electronic PDF Preferred)
- ☐ Part E and Part H of BI IRB application if using contrast agents or other medications, along with IRB approval documentation
- ☐ Submit all documents to the MRI Research at MRIResearch@bidmc.harvard.edu

ADMINISTRATIVE USE ONLY

Date Forms Received: MRI Schedule Study ID Title:

Approved Scan Rate: Approval from MR Research: