



Virginia Commonwealth University

Radiology Services Pricing Request

(please note: you must submit Protocol along with this form)

Date: _____

PI: _____

Contact: _____

Department: _____

Address (Box #): _____

Phone: _____

Fax: _____

Department of Radiology
 PO Box 980470
 Richmond, VA 23298
 Phone: 804.828.3993
 Fax: 804.828.6129
 www.radiology.vcu.edu

Study Information:

Title: _____

Sponsor: _____

Protocol #: _____

Est. Start Date: _____

Est. End Date: _____

Est. # of Patients: _____

Radiology Studies/Procedures Requested:

--

Imaging Location (select all that apply)	<input type="checkbox"/> Main 3 <input type="checkbox"/> Nelson Clinic <input type="checkbox"/> Stony Point <input type="checkbox"/> ACC <input type="checkbox"/> Nuclear Medicine
---	--

Has This Study received IRB approval? Yes No

Does The Study Require the Involvement of a Radiologist (i.e. to provide information not typically found in standard reports, RECIST/WHO reads, CRF completion, protocol oversight)? Yes No

If yes, please explain in detail:

--

Does the Sponsor/Protocol require any of the following:

- Site Survey/Questionnaire* Yes No
- QC/Test Images to be performed* Yes No
- Specific Technical factors for imaging^Δ Yes No
- Anonymized CDs to send data to Sponsor Yes No

*Please allow two to three weeks for review/completion

^ΔSubmit copy of Technical Manual to Radiology