CT research protocol proforma

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| **Study Name:** |  |
| **Investigators:** |  |
| **Ethics reference:** |  |
| **IRAS project ID:** |  |
| **Sponsor:** |  |
| **Funder:** |  |
| **Date of meeting:** |  |

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| **Study Synopsis:**(please include study design and aims/objectives) |  |

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| **CT protocols to be run:** |  |
| **Number of participants:** |  |
| **Number of scans per participant:** |  |
| **Are any scans part of routine clinical care?:** | [ ]  Yes – (please highlight which ones)[ ]  No |
| **Contrast volume and rate required:** (if applicable) |  |
| **Additional drugs required:** | [ ]  GTN[ ]  Metoprolol[ ]  Other (please list) |
| **How will your participants be arriving to AMIIC?:** |  |
| **Maximum permissible Radiation Dose:** (proof of agreed dose in ethics application required) |  |
| **eGFR lower limit:**  |  |
| **Who are the practitioner(s), as defined under IRMER, for this study?:**(Please see [https://www.rcr.ac.uk/sites/default/files/guidance-on-irmer-implications-for-clinical-practice-in-radiotherapy.pdf](https://www.rcr.ac.uk/sites/default/files/guidance-on-irmer-implications-for-clinical-practice-in-radiotherapy.pdf%20) for practitioner classification description) |  |
| **Image storage required:** | [ ]  PACS[ ]  Syngo.via[ ]  CD – supplied by investigators[ ]  Hardrive – supplied by investigators |
| **Person(s) responsible for image analysis:** |  |
| **Is a report required? If so, who will be responsible for this?:** |  |
| **Clinician to be present for the duration of the scan?:****(**This will be required for all cardiac scans. If a clinical scan is part of the protocol then the clinician is required to have an OUH Clinical Honorary contract) | [ ]  Yes[ ]  No |
| **AMIIC nursing support required?:** | [ ]  Yes – (please provide details)[ ]  No |
| **Specific days and/or times for scans:** |  |

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| **University grant code:** |  |
| **Contact for funding queries and invoicing:** | Name: |
| Email: |
| **Primary contact details for research project:** | Name: |  |
| Email: |   |
| Contact number: |  |
| **Secondary contact details for research project:** | Name: |  |
| Email: |  |
| Contact number: |  |
| *Please ensure that AMIIC is acknowledged on all publications and reference details are passed to the Operations Manager using the following wording:**‘We wish to acknowledge the facilities provided by the Acute Multidisciplinary Imaging and Interventional Centre’* |

**Please send a copy of the following documents to AMIIC Operations Manager/Lead Research Nurse**

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| **Research ethics approval letter** |[ ]
| **MHRA/HRA approval letter** | [ ]  |
| **OUH Trust R & D approval – if applicable** |[ ]
| **Approved study protocol** |[ ]
| **SLA for use of AMIIC facilities** (any study NOT sponsored by the University of Oxford) |[ ]

Action points:

|  |  |
| --- | --- |
|  | Name of attendee: |
| **AMIIC Director** |  |
| **Clinical lead** |  |
| **Nurse** |  |
| **Radiographer** |  |
| **Physiologist** |  |
| **Study investigator** |  |
| **Operations Manager** |  |
| **AMIIC study tag for Medesk use:** |  |
| **Anticipated start date:** |  |