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| **DIRECTIONS:** * **To schedule Radiology services for a research participant, complete this form and submit it by email to** Sandra Walker (SWALKER@gmh.edu); Joan George (JGEORGE@gmh.edu) and cc: Kathey Leach (KLEACH@gmh.edu).
* **Submit this Form at least 48 hours prior to the date/time of the appointment request**. Requests received immediately before the date/time being requested cannot be accommodated.
* **Appointment confirmation** **is routinely provided via email.** If the Submitter has not received email confirmation 24 hours prior to the requested appointment, please resubmit the request.
* Forward email appointment confirmations for research visits that include an MRI procedure to dstrozier@gmh.edu in Imaging Services.

**Please note:** * All communication for scheduling research appointments must be managed by the PI/Research Team
* It is the responsibility of the PI/Research Team to provide appointment information to the patient
* You must adhere to processes agreed upon with the Radiology Department regarding procedures/services for your study.

**If You Have Questions:*** Contact Radiology Services by email *(see contacts above)* with questions specific to scheduling for research participants.
* Contact the Office of Grant Administration at grants@gmh.edu with research related questions. Remember to submit the Research Patient Tracker Form after each visit.
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| **The asterisks (\*) Denotes Required Information** |
| **Research Study & Contact Information** |
| **Grady Plan Code \*** |       (e.g. E600. Refer to the study’s ROC Approval document) |
| **Principal Investigator Name** |       |
| **Requestor’s Name\*** |       |
| **Requestor’s Phone Number\*** |       | **Email\*** |       |
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| **Appointment Request Information** |
| **Ordering Clinician\*** |       |
| **Appointment Date & Time\*** (e.g., 01/01/18 **/** 9:30 am)*You may provide 3 options. If your choices are unavailable you will be notified*  |
| 1. /
 | 1. /
 | 1. /
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| **If this request is for an MRI or CT complete the appropriate questionnaire on page 2.** Research visits cannot be scheduled without the submission of the questionnaire. |
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| **Patient Demographic Information** |
| ***NOTE:*** The referenced patient MUST be “enrolled” into the study in Epic prior to transmitting this form |
| **Last Name\*** |       |
| **First Name\*** |       | **Middle Initial** |       |
| **Date of Birth\*** *(mm/dd/yy)* |       | **Gender** |       |
| **Medical Record Number\*** |       |  |  |
| **All patients MUST have a Grady MRN prior to submitting an appointment request.** |
| **Address** |        |
| **City** |       | **State** |       | **Zip Code** |       |
| **Phone Number** |       |

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| **Please respond to the MRI or CT Questionnaire on behalf of the research participant** |
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| **MRI Scheduling Questionnaire** |
|  | **Questions** | **Yes / No / Unknown** | **Comments** |
|  | Has the patient had any surgeries? If yes, document what type and date in comments |       |       |
|  | Does the patient have any type of metal implants, surgical clips, valves, a cardiac pacemaker, metallic stent, filter, coil or retained bullet, or buckshot in their body? If yes, please document in comments |       |       |
|  | Does the patient suffer from claustrophobia? If yes, please contact the ordering physician to prescribe medications. |       |       |
|  | Does the patient have a history of shortness of breath, asthma, seizures, hypertension, congestive heart failure, or kidney problems? If yes, please list in comments |       |       |
|  | Does the patient have a history of allergic reaction, respiratory disease, or heart disease? If yes, please list in comments |       |       |
|  | Does the patient have anemia or sickle cell trait? |       |       |
|  | Has the patient had any lab work (blood drawn) |       |       |
|  | What is the patient’s weight?If exceed limit, contact modality department for instructions. |       |       |
|  | Is the patient physical impaired or have any special needs (e.g. wheelchair, oxygen)? If yes, please list in comments |       |       |
|  | Does the patient require an interpreter? If so, please enter the language in the comments |       |       |
|  | Will general anesthesia be needed? |       |       |
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| **CT Scheduling Questionnaire** |
|  | **Questions** | **Yes / No / Unknown** | **Comments** |
|  | Is the patient diabetic. If yes, please enter diabetic MEDS in the comments |       |       |
|  | Is the patient allergic to iodine? If yes, please contact the ordering physician and advise him/her to contact the radiologist for instructions |       |       |
|  | What is the patient’s weight?If exceed limit, contact modality department for instructions. |       |       |
|  | Does the patient require an interpreter? If so, please enter the language in the comments |       |       |
|  | Will general anesthesia be needed? |       |       |