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| **DIRECTIONS:**   * **To schedule Radiology services for a research participant, complete this form and submit it by email to** Joan George ([JGEORGE@gmh.edu](mailto:JGEORGE@gmh.edu)); Shanterrie Williams ([STWilliams@gmh.edu](mailto:STWilliams@gmh.edu)); and cc: Leslie Letters, Outpatient Director of Radiology & Imaging Services ([LJLetters@gmh.edu](mailto:LJLetters@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](mailto: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 ORA-Finance at [researchfinance@gmh.edu](mailto:researchfinance@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\*** | |  | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **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. / | | | | | |
| **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. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **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** | | | |
|  |  | | |
| **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? |  |  |
|  | | | |
| **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? |  |  |