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:** |  |