UAB MEDICINE
RADIOLOGY

Research Quote Request

Date Requested:______________________

Study Title: ____

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Short Study Name: ____ FAP #: _______________________

PI: ____

Nurse Coordinator: __________________________________ Ext#:_______________ Email:___________________________

Other Contact: ______________________________________ Ext#:_______________ Email:___________________________

Location: ☐ TKC ☐ University Hosp ☐ Highlands ☐ Other: __________________________________ # of Patients: ______

Sponsor: ☐ Federal ☐ Industry ☐ Cooperative ☐ Investigator Initiated ☐ Other _________________________________

Metrics Required: Yes ☐ No ☐**:** ____

Please choose all that apply:

☐ Pre-site questionnaire ☐ Orderable Required ☐ Phantom ☐ Form Completion
☐ Site Initiation ☐ Tech/Radiologist Training ☐ Tech Time ☐ Special dictation

Clinical Imaging Services Summary: ____

☐ CT ____

☐ MRI ____

☐ PET ____ ☐ NUC. MED.____

☐ DIAGNOSTIC ___________________________________ ☐ ULTRASOUND ____

Has a UAB Radiologist been consulted regarding this study? Yes ☐ No ☐ If so, whom? ___________________________________

Will a Radiologist receive effort from this study? Yes ☐ No ☐ If yes, whom? ____

Image Transfer Required: ☐ CD ☐ FTP ☐ Other ____
Please submit image transfer requests to: rrimagetx@uabmc.edu

*** Non-routine research specific services (e.g., the completion of study forms, additional machine time, etc.) will be billed by Radiology Research. Routine services will be billed by the Health System.

Special Instructions: ____

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Please submit this form with your FAP submission or send the form to radresearch@uabmc.edu.

Revised: 9-7-2012