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| **Purpose:** The purpose of this form is to allow TGH Imaging Powered by Tower to assess the capabilities of clinical trials as early in the study startup process as possible. This form may also be used to produce imaging quotes that the USF or TGH Office of Clinical Research will use to negotiate the study budget with the sponsor.  Note: This form is ONLY for outpatient imaging. If your study needs inpatient imaging at TGH, please use [this](https://www.tgh.org/-/media/files/research-and-innovation/tgh-imaging-feasibility-form-tgh-main-hospital-and-brandon-healthplex10may2023.docx?rev=d9ec6b1efa734d5fb22ae8037fc11154&hash=5708E20FCD677994E4103C35C295FD31) form instead and submit it to [research@tgh.org](mailto:research@tgh.org).  **Instructions:**   * Complete sections 1 through 4 of the form below. * This form is currently set to track changes. Your text will be red, this is intentional. Please keep the form in this mode and submit this form as a Word document. * Utilize the checkboxes in the form below to answer questions and confirm that documents are included with your submission. |

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| **Section 1: Basic Study Information** | |
| Sponsor: |  |
| Short Name/Protocol Number: |  |
| Site Number: |  |
| PI Name: |  |
| PI Employer:  (This is required to know which entity is contracting with the sponsor) | USF; specify College of Medicine department:  TGH (or any of the following: Teamhealth, Florida Orthopedic Institute, Florida Kidney Physicians) |
| Study Coordinator’s Name: |  |
| Study Coordinator’s Email: |  |
| Type(s) of funding:  (Select all that apply) | Industry  Non- Industry |
| Patient Population:  (Age range, disease group, etc.) | Greater than or equal to 18 years old  Less than 18 years old  Disease group:  Other Information: |
| Projected Enrollment (for site): |  |
| Duration of Study (years): |  |
| High Priority? | Yes (OCR approval required)  No |

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| Section 2: Required Documents | |
| Please include the following documents along with this form. **The highlighted documents are required**. The remaining should be provided if they are available. | Study Protocol  Imaging Manual and/or Acquisition Guidelines (if the study has them, some studies where the imaging sequences/protocols follow standard modalities do not have these documents)  Digital Uploading and Query Management Manual (if separate/applicable)  Other Radiology Documents |

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| Section 3: Protocol-Specific Information | | Additional Comments: |
| Are test images required prior to protocol initiation? | Yes (i.e. setting print out, phantom/volunteer scan)  Please specify if the study team will be uploading test image(s):  Yes  No  No |  |
| Will the monitor conduct an On-Site Visit with Tower? | Yes; Date of anticipated site initiation visit (SIV; if known):  No    *If unknown, state TBD in the comments.* |  |
| Are the scans required to be anonymized? | Yes; please specify the naming convention:  No |  |
| Are there any sponsor-required trainings? | Yes; please specify personnel and responsibilities:  No |  |
| Does the study require Powershare? | Yes  No  *If Yes, who will upload the images?*  USF/TGH Research staff  TGH Imaging Powered by Tower tech (please note that TGH Imaging Powered by Tower staff will only upload the images if the sponsor requires images to come directly from the imaging team) |  |

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| Section 4: Imaging-Specific Information  Instructions:   * Please list all Protocol required imaging being requested from TGH Imaging Powered by Tower, even if SOC. * Do not complete the rightmost two columns, they are to be completed by the Clinical Research Coordinator for TGH Imaging Powered by Tower during their Review. * See references below:   + Imaging CPT codes:   + Imaging modality grid with available location(s) for service(s): * If a location map is needed, please click [here](https://www.tghimaging.com/locations/). | | | | | | | |
| **Item: Radiology Test Procedure**  **(Specify if contrast and/or special requirements needed)** | **CPT Code**  **(if known)** | **Exam Frequency Per Patient** | **Local/Central Read** | **Additional details/requests (ex. Special read requests)** | **Location:**  **(Desired TGH Imaging Powered by Tower Location)** | **Is this request feasible?**  **If no, specify constraints.** | **Is the location feasible? If no, specify other location(s) to accommodate the scan.** |
| Example Row:  Chest X-Ray | 71045 | 4 visits require the scan | Local and Central required. | 2 views | USF Health South Tampa Center | Yes  No; Specify: | Yes  No; Specify: |
|  |  |  |  |  | Choose an item. | Yes  No; Specify: | Yes  No; Specify: |
|  |  |  |  |  | Choose an item. | Yes  No; Specify: | Yes  No; Specify: |
|  |  |  |  |  | Choose an item. | Yes  No; Specify: | Yes  No; Specify: |
|  |  |  |  |  | Choose an item. | Yes  No; Specify: | Yes  No; Specify: |
|  |  |  |  |  | Choose an item. | Yes  No; Specify: | Yes  No; Specify: |
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|  |  |  |  |  | Choose an item. | Yes  No; Specify: | Yes  No; Specify: |

**RESEARCH TEAM, STOP, YOU DO NOT NEED TO COMPLETE THE REMAINING SECTION OF THIS FORM**

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| Section 5: TGH Imaging Powered by Tower Review  This section is to be completed by the Clinical Interface and Clinical Research Coordinator for TGH Imaging Powered by Tower. | |
| Are there any other concerns regarding this request? | Yes |  No  If yes, explain concerns: |
| Does TGH Imaging Powered by Tower accept this research imaging request, either as originally requested or as modified above based on scan location availability? | Yes |  No |