Clinical Research Lab
Request for Initial
Start-up Radiology Services

PI Name____________________________________
PI E-mail____________________________________
Department__________________________
Billing Dept # __________
Billing Contact Name ________________________
Billing Contact Phone _______________________

Research Coordinator ________________________
E-mail ______________________________________
Phone __________ Pager __________
Fax ____________________________
Campus Box ________________
Alternate Coordinator: ________________________
Email________________________ Phone __________

For CRL Use Only
Radiology Research Fees: (Effective Feb 1, 2014)
CRL Admin Fee
• $150 (for routine service requiring ≤1 hour)
• $300 (for service requiring > 1 hour time)

See Forms Selection Listing for Tier 1 & Tier 2 details.

Note: Additional Fees may apply due to customized services or services requiring more than one hour.
• Coordinator Fee: - $60/hour
• Test Images Fee: $60/case

Sponsor/and Study Title: ____________________________________________________________

Standard of Care Examination: ___Yes ___No
(IF NO, indicate the Radiology Research Examination Code (if applicable): __________

HRPO#________________________ Protocol #________________________ Site #__________ Request Date:__________

Study Information

Anticipated Start Date:_______________ Duration of Study:_________________________

Exam(s) needed (Check all that apply): CT___ MRI ___ US ___ X-Ray ___ Other: __________________________
Without Contrast ________ Or With Contrast ________
Type of Exam/Area of Body to be Imaged: ____________________________________________

Location of Exam (Check Preferred): BJH North Campus(CAM) ____ BJH South Campus ____ CCIR ____

   East Building (OP Research Only) ____ Children’s Rad ____ BJ West Cnty ____ BJ St Peters _______

   BJ South County_____

Number of Exams/Patient:_________ Anticipated Number of Patients:_________ Total # of Exams:_________

Data Collection Requirements (Please provide copy of protocol including information from Sponsor regarding specific requirements for data collection and storage. Please provide an Imaging Manual if available).

Image Transfer/Storage: CD-R Other Who will provide CDs?
(Please provide data collection/transfer information from Sponsor with specific instructions).

Person responsible for sending data to the Sponsor (i.e., Main Study Coordinator or CRL Coordinator)

Any other request? _________________________________________________________________

May be handwritten or typed, then emailed as a PDF to: crl-imaging@mir.wustl.edu
For questions call Darlene at 747-9448

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