Weill Cornell Medicine
Citigroup Biomedical Imaging Center
516 East 72nd Street, New York, NY 10021

Sponsored Research Order Form

Principal Investigator:_____ Dept. / Div.: _____

Phone: _____ Fax: _____ Email:_____

WMC IRB Protocol #: _____ Human Subject Certification #: _____

Protocol Title: _____

MANDATORY FIELD (Choose One):

☐ **Bill Research Grant/ Sponsor**

WMC Fund #: _____ Account Expiration Date: _____

Billing Address: _____

Patient / Subject Information:

Patient Name:_____ NYH # :_____

Referring Physician/ PI: _____ Telephone # :_____

Referring Physician Address: _____

Diagnosis: _____

Appointment Date: _____ Appointment Time: _____

(OVER)

Imaging Protocol Description:

MRI/ MRA :

☐ MRI Head ☐ MRI Abdomen ☐ MRA Abdomen ☐ fMRI

☐ MR Spectroscopy ☐ MRI Pelvis ☐ MRI Breast ☐ OTHER _____

☐ MRI Chest ☐ MRA Chest ☐ MRI Cardiac

Contrast:

☐ Without Contrast ☐ With Contrast ☐ With & Without Contrast

CAT Scan

☐ CT Head ☐ CT Chest ☐ CT Abdomen ☐ CT Pelvis

NUCLEAR MEDICINE:

☐ PET/ CT scan

☐ Whole Body ☐ Head ☐ OTHER _____

Other Procedures:

_____

_____

_____

Are you requesting to operate Scanner / Camera independently? Yes ☐ No ☐

Will there be any new devices that are introduced to the CBIC? Yes ☐ No ☐

If Yes, please explain: _____

_____

_____

Will you be requesting radiotracers from the Cyclotron? Yes ☐ No ☐

If Yes, **we are requesting that you please cite grant S10OD030447 on any manuscripts and conference abstracts in which data was collected.**

In addition to completing this form, please provide a copy of the following information:

1. Signed IRB approved and stamped consent form for all research subjects being scanned.

Please return form to: **Muc Du**, Box 234 (Room S-260A) or Fax to 746-6681. Any questions regarding form, please call Muc Du at 746-5883.

Study Authorization Signature: _____