THE CENTER FOR IMAGING OF NEURODEGENERATIVE DISEASES

High Field Magnetic Resonance Imaging Center
Research MRI Suite, Basement Floor of Building 203
VAMC 4150 Clement Street, San Francisco, CA 94121

MR STUDY APPLICATION for Research Users

Return application or direct questions to:
Katherine Wu, CIND Imaging Core Supervisor
Katherine.Wu@ucsf.edu
(415) 221-4810 x2-6472
Fax: (415) 379-5648

Application date:

PRINCIPAL INVESTIGATOR

Name:	Dept:
Address:	
Phone:	Email:

STUDY

Study Title:	
Study Nickname:	
Proposed start date:	Proposed end date:
Study Disease:	

GRANT INSTITUTION / FUNDING SOURCE - *Check all that apply.*

If applicable, please attach a copy of your PO.

☐ VA	PO#:		
☐ NCIRE	PO #:	Project #:	
☐ UCSF	PO #:	Project #:	Dept. ID #:
☐ Other	Bill To:	Address:	
		Phone:	Email:

Funding expiration date:

☐ Unfunded Potential Funding Source: Estimated Start of Funding:

Estimate of Use: _____ hr(s) per _________ Annual Ceiling Amount: $__________

CO-INVESTIGATOR(S)

Name:	Dept:
Phone:	Email:

Name:	Dept:
Phone:	Email:

SCAN TECHNICIAN(S) / OPERATOR(S)

Who will conduct your scans? *Check one.*

- ❑ CIND scan technician
- ❑ I (or members of my team) will scan. (*Please list all scan technicians or operators below.)*

Full Name	Phone	Email	VA STATUS (WOC) (Y/N)	CIND Certifications Level I (Y/N)	Level II (Y/N)	Level III (Y/N)

AUTHORIZED SCHEDULER(S)

Full Name	Phone	Email	VA STATUS (WOC) (Y/N)	Level I (Y/N)

STUDY TYPE - *Check all that apply.*

☐	SFVAMC 3T SIEMENS SKYRA	☐	SFVAMC 7T SIEMENS MAGNETOM

☐ **Phantom**

☐ ADNI phantom ☐ BIRN (agar) phantom ☐ NIST Diffusion phantom

☐ **Human** Approved CHR #: Expires:

☐ Normal Volunteers ☐ Patients

Study Disease:

☐ **Other** ____

To apply for a recurring slot, please fill out the following:

RECRUITMENT

	# of subjects
	# of scan sessions per subject
	Recruitment duration (years)

TIME PREFERENCE - *Please select all that apply.*

Day of Week:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Business Hours:

☐ Morning (9:00am–11:00am) ☐ Noon (11:00am–2:00pm) ☐ Afternoon (2:00pm–5:00pm)

Off-Hours:

☐ Early Morning (prior to 9:00am) ☐ Early Evening (after 5:00pm) ☐ Weekends _______________

***Note**: Unfunded studies are not granted recurring slots.*

*Please see **CIND Standard Policies** on how to schedule unfunded/development scans.*

SETUP

Additional equipment setup required in the:

☐ Console Room ☐ Magnet Room ☐ Other ______________________

(Box A)	hr	Estimated duration of equipment setup

PROTOCOL - DETAILED

COIL TYPE - *Please select all applicable*

3T Skyra Coils:

☐ 20 Channel Head/Neck ☐ 32 Channel Head ☐ Body

☐ 4 Channel Small Flex ☐ 4 Channel Large Flex ☐ 36 Channel Peripheral Angio

☐ 16 Channel Shoulder –Large** ☐ 16 Channel Shoulder – Small** ☐ 16 Channel Hand/Wrist** ☐ 15 Channel Transmit/Receive Knee (QED)**

7T Magnetom Coils:

☐ Nova Medical 1 Channel Transmit / 32 Channel Receive Head

*** These coils are shared with the VA Department of Radiology. If you plan to use any of these coils, you will need to make special arrangements directly with the VA Department of Radiology.*

MR Research Protocol - *If available, please attach a copy of the entire protocol.*

If a protocol is not available, please indicate that under "Notes" and explain why.

(Box B)	hr	Length of MR protocol

NOTES:

LIST **EVERY** ITEM THAT WILL BE TAKEN INTO THE MAGNET ROOM:

TOTAL **SETUP TIME** = __________ (hr:min) (Box A)

TOTAL **SCAN TIME** = __________ (hr:min) (Box B)

TOTAL TIME per **SESSION** (Box A + Box B + misc. time) = _______________ (hr)

(round to the nearest ½ hr)

Miscellaneous time includes: wipe-down, linen removal, equipment removal, image archival, putting back coils, etc.

IMAGE TRANSFER/ARCHIVAL

How data will be transferred off the system: ______________________________

How data will be backed up: ______________________________

ADDITIONAL ANCILLARY EQUIPMENT

Please select all ancillary equipment you intend to use

☐ fMRI
- *Avotec* Audio/Video Stimulus Capability
- Sound Compressor/Amplifier
- Response Pads, OTEC, and Controller, *Cedrus Lumina*
- Application Software, **E-Prime**

☐ EEG
- Head Cap – MR compatible 32 Channel Cap, *BRAIN PRODUCTS*
- Recording Software, *Brain Vision*

☐ Moiré Phase Tracking System for Prospective Motion Correct, *Metria Innocation Inc.*
- MPT High-Field Camera and Lighting Unit
- MPT Motion Tracking and Measurement Reporting System
- MPT Motion Tracking Markers**

***Please note that MPT motion tracking will require an additional materials fee.*

☐ fMRI Compatible Glasses

CLINICAL MRI READS

Please select an option regarding the post-acquisition evaluation of a patient.

☐ STENTOR – For participants with a medical record in the SFVA
- Will all subject scans require reads to be performed? ☐ Yes ☐ No

  If no, please provide rationale: ______________________________
- Are controls also being recruited? ☐ Yes ☐ No

☐ Other
- Please identify the group that will be performing the clinical reads for your study:

  ____
- How will images be transferred:

  ____

☐ None
- Please list the reason(s) for declining read reports:

  ____

ABSTRACT / STUDY AIMS

Please also include imaging goals by stating the number of subjects, number of scans and number of time points for your study.

Have you included everything? Check off materials included with your application:

ALL STUDIES

- ❑ Copy of PO form, if funded study
- ❑ Abstract / rationale for the proposed study (page 5)
- ❑ Copy of detailed Imaging Research Protocol (or complete page 7)
- ❑ Copy of VA TMS MRI Safety and Radiation Safety Trainings completion certificates for all staff who will utilize the scanner (separately attached)

HUMAN STUDIES

- ❑ Copy of CHR Approval Notification
- ❑ Copy of CHR-Approved VA Informed Consent
- ❑ Copy of CHR-Approved HIPAA
- ❑ Clinical MRI Reads Form (page 4)

By signing below, I have received a copy of the CIND Standard Policies. I have read, understood, and agree to the CIND Standard Policies.

____

PI's Name, Printed

____

PI's Signature

____

Date

Additional space, if needed.

MR Research Protocol - *Fill-in as much as possible, see last column for example.*

Series	1	2	3	4	*Example*
Sequence					*MPRAGE*
Type & Plane					*Sagittal*
Voxel Size					*1.0x1.0x2.0 mm*
Imaging Time (min:sec)					*5:30*
TR					*2300 ms*
TE					*2.98 ms*
TI					*1000 ms*
Flip					*9 deg*
Bandwidth					*240*
FOV					*256*
Fat Suppression					*Water excit. Fast*
PAT mode					*GRAPPA*
Accel. Factor PE					*2*
Matrix					*256x256*
Number of Averages					*1*
Phase Encoding Directions					*AP*
b-value					*n/a*
Diffusion Directions					*n/a*
# of b0s within Diffusion					*n/a*

Series	5	6	7	8	**Example**
Sequence					*MPRAGE*
Type & Plane					*Sagittal*
Voxel Size					*1.0x1.0x2.0 mm*
Imaging Time (min:sec)					*5:30*
TR					*2300 ms*
TE					*2.98 ms*
TI					*1000 ms*
Flip					*9 deg*
Bandwidth					*240*
FOV					*256*
Fat Suppression					*Water excit. Fast*
PAT mode					*GRAPPA*
Accel. Factor PE					*2*
Matrix					*256x256*
Number of Averages					*1*
Phase Encoding Direction					*AP*
b-value					*n/a*
Diffusion Directions					*n/a*
# of b0s within Diffusion					*n/a*

Additional Notes:

LEAVE BLANK. CIND USE ONLY.

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MR APPLICATION Approvals

✓ CHECKLIST

- ❑ CHR / VA current approval, consent
- ❑ CHR /VA approved investigators
- ❑ Fund / DPA/ PO valid for billing
- ❑ Imaging protocol reviewed, scan time appropriate
- ❑ Radiologist for human subject studies or Waiver
- ❑ Image archival requirements reviewed
- ❑ TMS Certificates

RECURRING SLOT APPROVED FOR:

Day of Week:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Time of Day:

____

Expires on:

____

Diana Truran Sacrey, Recharge Analyst and Chief Operations Manager - Checklist and funding reviewed and approved

Signature Date

Katherine Wu, Imaging Core Supervisor
Corrina Fonseca, Magnet Lead - Imaging protocol and procedures reviewed and approved.

Signature Date

Jacqueline Hayes Project Manager – CHR and Consent forms reviewed and approved

Signature Date

Duygu Tosun-Turgut, PhD, CIND Co-Director and Assistant Professor, application approved

Signature Date

LEAVE BLANK. CIND USE ONLY.

Approval Notes: