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

VAARC
VA Advanced Imaging Research Center

MR STUDY APPLICATION for Research Users

Email completed application or direct questions to:
Stephanie Rossi, CIND Imaging Core Supervisor
Stephanie.Rossi@ucsf.edu
(415) 221-4810 x2-6387
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.

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

AUTHORIZED SCHEDULER(S)

Full Name	**Phone / Extension**	**Email**	**VA STATUS (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 any and 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 <u>not</u> granted recurring slots.**

*To schedule Unfunded (development) scans, please see **CIND Standard Policies**.*

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 ☐ 32 Channel Spin Matrix ☐ 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.*

MR Research Protocol - *If available, please attach a copy of 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)
(rounded 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 EQUPIMENT

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**

☐ 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.*

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

☐ fMRI Compatible Glasses

☐ Other
_____
_____
_____
_____

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)

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

MR Research Protocol – *If you were unable to provide a copy of your protocol, please fill-in the table 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 SPACE, IF NEEDED.

Additional Notes:

LEAVE BLANK. CIND USE ONLY.

MR APPLICATION
Approvals

VAARC
VA Advanced Imaging Research Center

✓ 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

RECURRING SLOT APPROVED FOR:

Day of Week:

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

Time of Day: _____

Expires on: _____

Diana Truran Sacrey, VAARC Director of Operations - Checklist and funding reviewed and approved

Signature Date

Stephanie Rossi, Imaging Core Supervisor - User certifications reviewed and approved. Slot assignment approved (if applicable

Signature Date

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

Signature Date

An Joseph Vu, MR Physicist and Technical Director – Imaging protocol and procedures reviewed and approved.

Signature Date

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

Signature Date

CIND Approval Notes: