Skåne University Hospital (SUS)
Department of Imaging and Functional Medicine
(VO Bild och funktion/BoF)

Date: YYYY-MM-DD

Modality Appendix for Research Collaboration

This appendix is mandatory for all research projects conducted in collaboration with or within the Department (VO) of Imaging and Functional Medicine (BoF), Skåne University Hospital (SUS)
NOTE: A separate appendix must be submitted for each imaging modality included in the project

Clinical Research Council

Department of Imaging and Functional Medicine Skåne University Hospital - BoF SUS

Projet Title:

BoF Number *(filled by BoF)***:**

Modality:

Specify the research question and which body part(s) will be examined:

For MRI, specify intended magnetic field strength:

Total number of research subjects/persons and estimated number to be screened:

Number per group (if applicable):

Number of examinations per research subject:

Specify the time interval between examinations:

Indicate how many, and which, of the listed examinations would possibly have been performed clinically anyway:

Who will be responsible for including (enrolling) research subjects in the study?

Who is responsible for obtaining signed informed consent?

What preparations are required for the subjects prior to the examination?

Is phantom imaging or other certification required?

☐ No

☐ Yes

If yes, specify the type and extent:

Is special image transfer required?

☐ No

☐ Yes

If yes, specify:

Is any preparatory work and/or training required before image transfer?

☐ **No**

☐ **Yes**

If yes, specify what kind and to what extent:

Is tracer, contrast agent, or any medication required for the examination?

☐ **No**

☐ **Yes**

If yes, specify type, dosage, course of administration, and any contraindication:

Is a specific examination method or protocol required?

☐ No, the examination will be performed entirely according to the clinical protocol

☐ Yes

If yes, specify and attach the Imaging Guide/Procedure Manual

For MRI enter information in table (DO NOT FILL IF Imaging guide/procedure manual is ATTACHED).

Squence Type (i.e.T2 Flair)	Orientation(i.e.AXIAL)	Estim. Scan Time (mm:ss)

Total Scan Time (mm:ss):

Preferred examination times and days:

Should examination be performed on specific equipment?

Should examinations be coordinated with another visit?

Who is responsible for scheduling the patient for the examination?

Examination Code (*filled by BoF)*

Estimated time per examination session *(filled by BoF)***:**

Will images be processed according to a study-specific method?

☐ No

☐ **Yes**

If yes, specify and attach the Imaging Guide/Procedure Manual:

How will images be archived?

☐ PACS at BoF according to clinical routine

☐ External drive or equivalent

If external, specify:

Will images be transferred for external image review or similar?

☐ No

☐ Yes

If Yes, specify how and by whom (attach manual if available):

How will images be interpretated/dictated?

☐ Routine review according to standard diagnostic reporting procedures

☐ Study-specific assessment and dictation

If study-specific, specify type of assessment and who will perform it:

Additional Information:

Notes by the Clinical Research Council: