

# MR STUDY APPLICATION for Research Users

Email completed application or direct questions to:  
Stephanie Rossi, CIND Imaging Core Supervisor  
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(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.*

<input type="checkbox"/> VA	PO#:		
<input type="checkbox"/> NCIRE	PO #:	Project #:	
<input type="checkbox"/> UCSF	PO #:	Project #:	Dept. ID #:
<input type="checkbox"/> Other	Bill To:	Address:	
		Phone:	Email:

Funding expiration date:

<input type="checkbox"/> 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 / Extension	Email	VA STATUS (Y/N)	CIND Certifications		
				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.*

<input type="checkbox"/>	SFVAMC 3T SIEMENS SKYRA	<input type="checkbox"/>	SFVAMC 7T SIEMENS MAGNETOM
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☐ **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 not 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☐ 16 Channel☐ 16 Channel☐ 15 Channel

Shoulder –Large\*\*

Shoulder – Small\*\*

Hand/Wrist\*\*

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 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 Innovation Inc.*

- MPT High-Field Camera and Lighting Unit
- MPT Motion Tracking and Measurement Reporting System
- MPT Motion Tracking Markers\*\*

☐ fMRI Compatible Glasses☐ Other*\*\*Please note that MPT motion tracking will require an additional materials fee.***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**

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

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

**Additional Notes:**



# 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:*


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

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 Signature

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 Date

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

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 Signature

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 Date

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

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 Signature

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 Date

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

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 Signature

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 Date

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

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 Signature

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 Date

**CIND Approval Notes:**