**UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE**

**DEPARTMENT OF RADIOLOGY**

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|  | **Swati Rane Levendovszky PhD** **Department of Radiology**University of Washington1959 Pacific Ave Seattle,HSB AA038, Box 357115Seattle, WA 98195Phone: (206) 685-0457Fax: (206) 543-6317 |

TO: All users of DISC Resources

FROM: Swati Rane PhD, Director MR Research Lab

SUBJECT: Approved Cost Center Rates for the 3T MR Research Magnet in AA-048

The rates below for the MRI Research Center are as follows (04-01-2021 to 03-31-2022)

MR use time is billed as total room time when the imaging unit cannot be accessed for use by other studies. Room time is pro-rated in 15-minute intervals. Minimum scan time is 30 minutes.

Hourly MR charges with UW budget# Human - $664 per hour

Animal- $664 per hour

XNAT data storage fee $26 per subject

Consultation service $225 per hour

Contrast $105 per unit (20cc vial)

Physician charge for contrast oversight $65 per session

Retrospective retrieval of exam $110 per exam

**Disclaimer:**

* Charges for MR scan time and supplies will be assessed on a monthly basis to appropriate budgets.
* Please contact DISC for invoice rate and outside rates
* Supply charges may change without notice since these are based on actual costs to the MR Research Center.
* Charges do not include nights and weekends or after hours. Regular hours = 8 am - 5pm
* The above charges do not include costs related to consultation time with MR scientists and physicians, study interpretation, study monitoring, specialized RF coil development, device construction for a special type of experiment, or new pulse sequence development. Funding for this support should be discussed with the lab director and/or with the individual scientist or physician providing support.

**CHECKLIST FOR INVESTIGATORS SUBMITTING A PAF**

**[ ]** Completed Project Application Form (PAF)

**[ ]** Accurate budget information or estimated hours for pilot study

**[ ]** Project description

**[ ]** Approved IRB with approval #

**[ ]** Copy of approved stamped consent form

**[ ]** Protocol to be used in the study

**[ ]** PI signature

**[ ]** Appropriate Safety Training

**PLEASE EMAIL COMPLETED FORM TO**

**discsupp@uw.edu**

**RESOURCES FOR STUDY PERSONNEL**

**DISC 3T Contact Information:**

Director of MR Research Laboratory:

Swati Rane Levendovszky PhD

MR Physics

srleven@uw.edu

206-685-3538

MR Technical Support: MR Analysis Support Administration IT Support

Tim Wilbur Cole Anderson Liza Young Tina Guan

twilbur@uw.edu colea222@uw.edu liza14@uw.edu qguan@uw.edu

206-543-6159 206-685-1604 206-685-0457 206-685-5456

DISC Website: <https://depts.washington.edu/mrlab>

Online Scheduling: <https://depts.washington.edu/mrlab/3T_mod/week.php>

Scheduling Policies: <https://depts.washington.edu/mrlab/research/researcher/scheduling.shtml>

Safety Training: <https://depts.washington.edu/mrlab/SafetyTraining_Basics/00_certification.shtml>

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| **HUMAN AND *IN VITRO* PROJECT APPLICATION FORM** |

**A. GENERAL INFORMATION**

**Project Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Principal Investigator** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/UW Box #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department or Affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEPHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a CHDD research affiliate? **[ ]**  Yes **[ ]**  No

If yes, does the project conform to the Mission of the CHDD **[ ]**  Yes **[ ]**  No

Are you a UW-FHCRC Cancer Consortium Member? **[ ]**  Yes **[ ]**  No

**IRB Approval Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provide copy of stamped/approved IRB form

**Link Destruction Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(**Date listed in IRB approval for destruction of subject I.D. link to identifier information if applicable)

**Anticipated Start Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_**

**Projected End Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Human Study [ ]  In Vitro [ ]**

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| **Total No. of Subjects to be scanned** \_\_\_\_\_  **\_** |

**Duration for each imaging session** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Total number of imaging sessions per subject** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Request XNAT for service for subject scanner data archive and retrieval** Yes No

**B. CONTACT INFORMATION – PRIMARY OR OTHER**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Role | Department | Phone | E-Mail | Check if primary contact |
|  |  |  |  |  |  |
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**C. STUDY FUNDING**

 **Source of Funding**:­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Title of Award**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Duration of Award (Please include end date):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Total Award Amount**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **UW Budget Number to be billed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Or, if scans are to be invoiced**

 PO# ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***NOTE:*** *The MR Research Lab supports a limited number of pilot study hours on a competitive basis. Proposed Pilot projects must be discussed with lab director prior to submission of request. Final approval will follow evaluation by the Laboratory Review Committee.*

**D. STUDY INFORMATION**

**Brief statement of project description:** Please include (1) Objectives (2) Research Plan (3) Expected Results. OR on separate pages attach a brief description of the project (not to exceed 5 pages).

OR include a copy of grant abstract (e.g., Page 2 of NIH form).

**E-J. MR PROCEDURES**

**E**. Please check:

 **[ ]** Anatomical (T1/T2/T2\*) **[ ]** fMRI **[ ]** MRS **[ ]** MRA **[ ]**  DTI **[ ]** Perfusion MR **[ ]** Other

(Attach imaging and/or spectroscopy protocol to be used, if available.

Will this study use an existing scanning protocol? **[ ]** Yes **[ ]** No

If No, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For questions below, if yes, please discuss with Lab Director or Lab Manager.***

 **Yes No**

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| **F. [ ]**   **[ ]**  | MRI Contrast agents such as gadolinium will be used*WA State licensed MD must cover injections* |
| **G. [ ]**   **[ ]**  | Radiotracers will be used\*\* |
| **H. [ ]**   **[ ]**  | Hazardous chemicals, inhalation anesthetic or infectious agents will be used*Procedures to prevent contamination of MRI personnel must be provided and followed.* |
| **I. [ ]**   **[ ]**  | Investigators will bring equipment into the MRI facility. (*Note: In addition to overall study approval, prior written approval for any equipment brought into the MRI Lab is necessary for safety of personnel and equipment.)* |
| **J. [ ]**   **[ ]**  | Informal radiologist review will be required*(If yes, provide name of reviewer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)* |
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**\*\*Restrictions apply to the usage of radioactive materials. The licensee is responsible for clean up and removal of all radioactive materials after each experiment. No facilities at the MR Lab are available for storage of radioactive or biohazardous materials.**

**Any modification to the existing protocol that changes the Risks and/or Procedures
must be formally submitted for approval as an addendum to this application (e.g., replacing equipment, new drugs, new coils, etc.)**

**I have read and agree to follow the Policies and Procedures outlined in the MR Lab Standard Operation Procedures, available on-line at** [***http://depts.washington.edu***](http://depts.washington.edu)**/mrlab/**

**Principal Investigator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email completed forms and attachments to** **discsupp@uw.edu**

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**FOR OFFICE USE ONLY**

**Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Director, For the Review Committee**