UW Medicine
HARBORVIEW
MEDICAL CENTER

UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER

UNIVERSITY OF WASHINGTON IMAGE GALLERY INTAKE FORM

Fill out one intake form completely for each type of equipment requested and return to mcsos@uw.edu;

Name of Group/Specialty/Clinic (Specify) _____

Name of person submitting form and contact information:

_____
| Name   email   Phone |

I. Device/Equipment Information
- What type of device/equipment is it? _____
- Location of device/equipment ☐HMC ☐ UWMC ☐ SCCA ☐ ROOS ☐ ESC ☐ OTHER_____
- How is PHI captured with this image?

  _____
- Image Format being stored ☐ DICOM ☐ JPEG ☐ PDF ☐ PNG ☐ TIFF ☐ MOV ☐ AVI

  ☐ OTHER _____

❖ **For DICOM images:**
- Modality Type ☐CR ☐DR ☐RF ☐XA ☐MRI ☐CT ☐US ☐OT ☐ Other_____
- Application Entity Title (AET) _____
- IP Address ____.____.____.____
- Port _____
- Modality Work list Y/N

II. Storage Requirements
- Are there historical images that you would like stored? ☐Yes ☐No
  If yes, please explain:

  _____
  _____
- Expected Volume: ☐ Weekly_____ ☐ Monthly_____ ☐ Yearly_____
- Average Size of single image: ☐ 1-3MB ☐ 5-10MB ☐ Over 10MB
- Compression: ☐ Non Compressed ☐ Compressed
- How do you expect to transfer the information into Image Gallery? _____

  _____
  _____
- Retention Requirements ☐ 1- 2 Years ☐ 3 Years ☐ 5 Years ☐ More than 5 Years
- Images will be stored locally. You have an option to store a second copy. Are you interested in finding out more? ☐ Yes ☐ No

III. PHI and other information to be stored. Please check all that apply.
Indicates required.

*☐ Patient Name   *☐ MRN [select all that apply] -- ☐ EPI# ☐ H# ☐ U#

*☐ DOB   ☐ Age   * ☐ Sex

*☐ Study Date/Time   *☐ Study Description

☐ Patient Location   ☐ Department Location

☐ Ordering Physician   ☐ Requesting Physician   ☐ Attending Physician

☐ Acquisition Device Name ☐ Manufacturer of Device

- Will Order numbers need to transfer? ☐ Yes ☐ No If Yes, explain how_____
- Others (Specify)_____

IV. Designated Administrational Person's Contact Information
   This person will be the main contact for emails sent for planned and unplanned downtimes, upgrades, and other notifications.
   - Contact Name _____
   - Email _____
   - Phone Number_____
   - Clinic/Department Name _____
   - Contact Person's Location ☐ HMC ☐ UWMC ☐ SCCA ☐ ROOS ☐ ESC ☐ OTHER _____

V. In addition to the administrative person listed above, who would need to be contacted for Image Gallery downtimes, upgrades, etc? *These users will also get access to Image Gallery.*

User Name	User Role	User Phone	User Email

VI. Users needing access to Image Gallery that do not need email updates:

User Name	User Role

VII. Clinical Engineering – Did you contact CE? Who and When?

User Name	Date

VIII.

IX. Describe your current workflows (how do you acquire images and how do you send them Ex: acquire images by phone and store on PC then Push to PAC. Do you take stills & video?)

_____

_____

_____

_____

_____

_____

X.   Do you already access images? How?

☐ Epic   ☐ ORCA   ☐ Mindscape URL (direct)   ☐ Other

<div style="background:#d9d9d9">

Section below to be filled out by Radiology IT

</div>

I.   What options are we looking at as possible means of image transfer?

☐ Media Manager   ☐Media Manager web
☐ DICOM   ☐ HL7
☐ Mobile   ☐

II.   What would a future workflow look like?

_____

_____

_____

_____

_____

III.   What reporting needs would they have?

_____

_____

IV.   Can we meet their needs?   ☐ Yes   ☐ No

Explain:

_____

_____

_____

_____

_____

_____

_____