**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) 685-3538Fax: (206) 543-6317 |

TO: All users of DISC Resources

FROM: Swati Rane PhD, Director DISC

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 (06-01-2023 to 05-31-2024)

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.

Hourly MR charges with UW budget# Human - $696 per hour

Animal- $696 per hour

Hourly MR charges for external clients Contract DISC directly to inquire.

 (includes 15.6% institutional overhead)

XNAT data storage fee $29 per session

Consultation service $258 per hour

Blood draw service $29 per session

Contrast $105 per unit (20cc vial)

One-time project start-up/consultation fee $258 per hour

Physician charge for contrast oversight $65 per session

Retrospective retrieval of exam $121 per exam

Phantom scans for site qualifications $369 per hour

Synthetic MRI $205 per 15-minutes (includes XNAT rate in it)

**Disclaimer:**

* Please note that site qualification scans are charged like regular MRI scans.
* 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. These rates apply to UW budget numbers only.
* 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.
* Any test scan for qualifying purposes will be charged once an account is set up and/or once the study is approved.
* Cancellation charges apply:
	+ Cancellation/notice less than 24 hours = full rate
	+ Cancellation 24-48 hours = 1/2 full rate
	+ Cancellation 48-60 hours = 1/4 full rate
* Project start-up fees/Consultation fees apply (see rates above).

**CHECKLIST FOR INVESTIGATORS SUBMITTING A PAF**

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

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

**[ ]** Project description

**[ ]** Approved Animal Medicine Committee application with with approval #

**[ ]** Copy of IACUC approved application with current stamped approval date and number

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

**[ ]** PI signature

**[ ]** Appropriate Safety Training: <https://depts.washington.edu/mrlab/research/safety.shtml>

**PLEASE EMAIL COMPLETED FORM TO**

**discsupp@uw.edu**

**RESOURCES FOR STUDY PERSONNEL**

**DISC 3T Contact Information:**

Catherine Delos Santos

Program Ops Specialist

cdsantos@uw.edu

206-685-0457

Director of DISC:

Swati Rane Levendovszky PhD

MR Physics

srleven@uw.edu

206-685-3538

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| --- | --- | --- |
| MR Technical Support: | MR Physics Support: | MR Analysis Support: |
| Tim Wilbur, MRSO (MRSC™) | Jason Ostenson, PhD | Cole Anderson |
| twilbur@uw.edu  | ostenj@uw.edu  | colea222@uw.edu  |
| 206-543-6159 | 206-685-1604 |  |
|  |  |  |
| IT Support: | Phlebotomy Support: |  |
| Tina Guan | Luisana Valero |  |
| qguan@uw.edu | luisanvp@uw.edu |  |
| 20-685-5456 |  |  |

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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| **ANIMAL 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

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

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

**Type of Animal Study Requested: [ ]  BSL-1 [ ]  BSL-2 [ ]  Non-UW**

**Animal Type: [ ]  Primate [ ]  Rodent [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**XNAT** is a charged, data management services to store and share data from the scanner. Costs are on the title page.

**Request XNAT for service for subject scan data archive and retrieval [ ]** Yes  **[ ]** No

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name | Role (Describe all roles for each individual: Coordinator) | Department | Phone | E-Mail | Check if primary contact | Check if XNAT access is needed | Check if access to MRI scan calendar is needed |
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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 information**: Note that all three are required.

Cost Center \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program/Gift/Grant Worktag \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intercompany Affiliation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **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).

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| 1. **Indicate who will be responsible for animal imaging for study**
 |
| [ ]  DISC core personnel  |
| [ ]  DISC Certified scan operator associated with study *Specify Name and date of certification* |
| 1. **List the following for animals to be imaged**
 |
| Number       Species       |
| **Duration and number of scanning sessions requested** |
| **Duration for each imaging session**      **Total number of imaging sessions per animal**      **Schedule of imaging sessions if serial study**      |

| 1. **Indicate whether the animals to be imaged have been exposed to any of the following**
 |
| --- |
| **NO** | **YES** |
| [ ] [ ] [ ] [ ]  | [ ]  Infectious and hazardous agents (If yes, describe agents & usage precautions below)[ ]  Human cells or blood (If yes, describe usage precautions below)[ ]  Viral vectors (If yes, describe vectors & usage precautions below)[ ]  Radioisotopes |

***If "yes" to any of question number #3 above, please describe the agents or viral vectors that will be used and the precautions that will be taken to prevent personnel exposure: (Per the DISC SOP you must also include a copy of any IACUC appendix to the assigned BSL)***

| 1. **Use of Contrast Agents**
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| --- |
| [ ]  No contrast agents will be used[ ]  Contrast agents will be used in this study. If yes, please answer the following:Provide the following information for each contrast agent:Route & frequency of administration       Volume per injection & total volume per imaging session       |

1. **Describe any procedures or treatments that will be given or performed on the animal(s) prior to or during imaging (e.g. Tail vein injections, perfusion, oral administration, etc.)**
2. **Describe the agents used for anesthesia (name of the agent, administration, dosage, monitoring method)**
3. **Indicate any additional instrumental equipment will be used:**

**Will the investigators bring any equipment into the MRI facility? [ ]** Yes **[ ]** No

**If Yes, please list equipment and include model # and manufacturer and indicate Vendor certification.**

1. **DISC policy on rodent handling**

[ ]  I have read and agree to adhere to the Standard Operational Procedures (SOP) using animals in DISC.

[ ]  I have read and agree to adhere to the DISC Policy on rodent handling in DISC with the following exceptions. (list exceptions and provide scientific justification for requested change)

1. **Applicants - UW and Non-UW**

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| For Non UW applicants, please indicate the name of the Non-UW institute from which the animals originate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  A copy of the IACUC approved animal protocol including any appendix from the **non-UW** institution is attached. |
| [ ]  A copy of a complete protocol animal application for approval by the UW IACUC is attached. |
| [ ]  A copy of a Research Project Hazard Assessment (RPHA) form approved by UW EH&S is attached. |
| [ ]  A copy of a Research Project Hazard Assessment (RPHA) application for approval by UW EH&S is attached. |

**E. 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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**\*\*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.**

**[ ]  We request notification by email to** **discsupp@uw.edu** **whenever information gleaned from DISC use is published. We use this information for site qualification and to comply with internal and external reporting requirements. Checking this box indicates acknowledgement of this requirement.**

**[ ]  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.). Checking this box indicates acknowledgement of this requirement.**

**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**