**Yale University PET Center Protocol Initiation Form**

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| **Contact Information** |
| **PI Name / Department** |  |
| **PI email address** |  |
| **PI phone #** |  |
| **Coordinator Name/Email/Phone#** |  |
| **Scheduler Name/Email/ Phone #** (if different from Coordinator) |  |

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| **Protocol and Funding Information** |
| **Protocol Title** |  |
| **HIC#** |  |
| **Have Approvals Been Received?** | **IRB** [ ] Yes [ ] No [ ] Pending, Submission Date:**RIDC or RDRC** [ ] Yes [ ] No [ ] Contingent Approval [ ] Pending**YU RSC** [ ] Yes [ ] No [ ] Pending**List Other, if applicable (PRC, Y-NHH RSC):**  |
| **Project Duration (Years)** |  |
| **Subject** **Population** | **Diagnoses:** |
| **Total # to be scanned:**  |
| **Expected Start Month:** |  |
| **Funding Source(s)** (list all approved sources on file with the IRB) |  |
| **COAs****Primary****Other** | [ ] Single Funding Source [ ] Multiple Funding Sources |
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| **Billing Notes**(specify if costs will be split between multiple accounts) |  |
| **Billing Contact:****(Name, Email, Phone#)** |  |

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| **Operational Information** |
| **Scanner****(Choose all scanners listed in the protocol)** | [ ]  **HRRT** [ ]  **mCT** [ ]  **Vision** [ ]  **NX**[ ]  **N/A (injection only)** |
| **Tracers:** |  |
| **Tracer Source** | [ ]  **Yale PET Center** [ ]  **Purchased/Delivered**  |
| **If purchased, provide source, contact name, and phone # for ordering:** |  |
| **If purchased, dose delivery time window:** |  |
| **Number of Scans per Subject** | [ ]  **1** [ ]  **2** [ ]  **3** [ ]  **Other:** **If multiple scans, provide information regarding number of days or amount of time between scans:**  |
| **Time/Day Restriction, if required** |  |
| **Arterial Line** | [ ]  Yes, Required for all scans[ ]  No, no blood sampling[ ]  No, venous sampling only[ ]  Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***(list if arterial plus venous sampling is requested, arterial line requested or specific populations, etc)* |
| **Pharmacologic Compound (i.e. cold non-radioactive drug), if applicable:** |  |
| **Will medical / nursing be provided by PI?:** **If yes, list Name/email/Phone#** | [ ]  Yes [ ]  No |
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**For Internal Use Only:**

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| **Date Received by PET Center** |  |
| **Assigned PET Center Short Name** |  |