Protocol Radiation Use Sheet

Study Title:

PI:

The information in this form will determine the level of review at the Human Use Subcommittee of the Radiation Safety Committee (HUS/RSC). Imaging that requires HUS/RSC review include: X-Ray, Bone Scans, MUGA Scans, CT scans, PET scans, PET/CT scans, Bone Density Scans, Mammograms, Skeletal Surveys, Fluoroscopy, or any type of radiation therapy or radioactive agent.

Standard of Care: Scans are consistent with standard clinical care that would be obtained on patients with this disease as part of their routine care, whether or not the patient was enrolled into this research study.

Study-Related: This exceeds what would be considered standard clinical care that would be obtained on patients with this disease, and is being done for the purposes of this study.

If you have any questions please contact:

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Please check the box below that best corresponds with the life expectancy of the patient population to be studied:

- [ ] ≤2 years
- [ ] 2-5 years
- [ ] 5-10 years
- [ ] ≥10 years

***On average how long would you expect a patient to remain on this trial? __________months

***Length of cycle (i.e: days) = ________________________________________

Type of Imaging: _______________________

☐ All scans are considered Standard of Care

☐ Some scans exceed Standard of Care. Please identify below:

1) Screening:
   ☐ Study-Related

2) Every 6 weeks
   ☐ Study-Related

COMMENTS: __________________________________________________________

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Number of _____ scans to be performed in one year period of time = ___

Type of Imaging: ____________________________

☐ All scans are considered Standard of Care

☐ Some scans exceed Standard of Care. Please identify below:

   3) Screening:
      ☐ Study-Related
   4) Every 6 weeks
      ☐ Study-Related

COMMENTS: __________________________________________________________

________________________________________________________________________________________

Number of _____ scans to be performed in one year period of time = ___

RADIATION

☐ All radiation is considered Standard of Care

☐ Some radiation exceed Standard of Care. Please identify below in comments:

COMMENTS: __________________________________________________________

________________________________________________________________________________________

PI Signature: ____________________________ Date: ______________