

RADIOLOGY RESEARCH IMAGE TRANSFER REQUEST FORM

Date:	IRB #:							
Requestor's Name:	PI:							
Requestor's Telephone:	UAB Oracle Account Number:							
Requestor's UAB Address:	Study Title:							
Requestor's E-mail:	Return To (Name and Location):							
RAD ID # (if available):	Short Study Name:							
Sponsor: <input type="checkbox"/> Industry Method of Transfer: <input type="checkbox"/> Federal, Cooperative Group, Investigator-Initiated <input type="checkbox"/> CD <input type="checkbox"/> Other _____ <input type="checkbox"/> Electronic Upload / Other _____								
<input type="checkbox"/> URGENT (needed within 72 hours – please make these requests before or immediately upon completion of the scan and you must contact the imaging coordinator at 205-975-4559 for approval) Data Transmittal / Imaging Form Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Special Instructions/Comments: _____								
Subject ID	Medical Record #	First Name	Last Name	DOB	Date of Visit	Study Visit #	Type of Scan (CT, MRI, PET)	Location of Scan (TKC,UABH, Highlands)
1.								
2.								
3.								

***** E-mail to imagetx@uabmc.edu OR FAX to 205-996-2031 *****

- * ALL PHI DATA WILL BE DE-IDENTIFIED WITH A SUBJECT ID. FOR IDENTIFIED INFORMATION, PRIOR APPROVAL WILL BE NECESSARY.
- * YOU MAY ADD ADDITIONAL ROWS TO THIS FORM AS NECESSARY.
- * SUBJECT ID WILL REPLACE THE PATIENT'S NAME – THIS CAN BE ANY ID THAT YOU WOULD LIKE.
- * IMAGE TRANSFER REQUESTS ARE TYPICALLY COMPLETED WITHIN ONE WEEK OF RECEIPT.
- * IMAGES MAY BE PICKED UP IN THE GENERAL SERVICES BUILDING SUITE 366 DURING NORMAL BUSINESS HOURS.