**Pro-forma for Provision of Service for Research - Adult Echocardiography**

R&D Number:       Date of Discussion:

*This form should be completed and agreed with the manager of the service to be used or by a designated individual notified by the service manager to R&D. Adult echocardiograms are performed by the adult radiology department.*

*The form should either be signed and returned hard copy to the Research Management Office or attached to an email from the service manager, indicating their authorisation, sent to* *ResearchApprovals@UHBW.nhs.uk*

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| **Service:** | **Echocardiography (Radiology)** | **Service Manager:** | **Martin Nelson / Sarah Fairbairn** |
| **Study Title:**  |
| **Principal Investigator (PI) at UHBW:**      Tel:       | **Point of Contact (PoC) at UHBW:**      Tel:       |
| **Sponsor:** |       | **Funding organisation:**  |       |
| Is this a commercially sponsored study? | [ ]  Yes | [ ]  No | How will the costs outlined below be met?       |
| Estimated study start date (at this site):      /     /      | Projected study end of recruitment date:      /     /     Projected end of support department involvement date:      /     /      |
| Do the current negotiations relate to: | [ ] [ ]  | Feasibility (e.g. for funding application or sponsorship request)Trust R&D Approval | Estimated number of participants:       |

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| **Service Required** | **Cost per unit** **(if above routine care)***To be completed by Service Manager*  | **Cycle / Visit**\*\*Please specify for each Cycle or Visit if each parameter is considered routine care (RC) or over and above routine care (X) in the boxes provided. |
|  |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
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|  | **Total Cost per Cycle / Visit:** |       |       |       |       |       |       |       |       |       |       |

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| **Any Special Arrangements/Requirements (e.g. time constraints, remuneration, storage requirements) should be indicated below. Trust Approval for this research study will be based on the information as provided:** |
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**PACS requirements (i.e. anonymised copy scans) if required**

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| **Imaging procedures requiring copy scans (please separate out imaging areas e.g. CT chest, CT abdomen etc.)** | **Number required per patient** | **Frequency (i.e. every 6 months)** | **Types of copy scans required (include anonymisation requirements and details of when required – e.g. maximum 2 days after scan to confirm eligibility?)** | **Details of image transfer required e.g. ODIE and a nominated UHBW e-mail address to receive image link, and any applicable timeframes** |
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| **Resource Authorisation**To be completed by Service Manager. The form may either be signed or returned via email from the signatory’s UHBW email account |
| **Feasibility Request:** I confirm that the resource requirements for this study are reasonable and the costing information can be included in applications. If this study goes ahead in this form it is likely to be supported by this service.Not Applicable [ ]  I agree [ ]  I do not agree [ ]  Date:      /     /      |
| **R&D Approval:** This service will support this study based on the information outlined aboveNot Applicable [ ]  I agree [ ]  I do not agree [ ]  Date:      /     /      |
| **Name:** | **Signature:** |

**PACS Authorisation is required for capacity of PACS team to fulfil copy scan requests.**

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|  | Name | Signature | Date |
| Head of PACS authorisation |  |  |  |