

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			
Other <input type="checkbox"/> Other _____				<input type="checkbox"/> Electronic Upload /			
<input type="checkbox"/> URGENT (needed in less than 48 hours)							
Special Instructions/Comments:							
Subject ID	Medical Record #	First Name	Last Name	DOB	Date of Visit	Type of Scan (CT, MRI, PET)	Location of Scan (TKC, UABH, Highlands)
1.							
2.							
3.							

***** FAX to 205-996-2031 OR E-mail to radresearch@uab.edu *****

*PLEASE USE A NEW PAGE FOR ADDITIONAL SUBJECT SCANS.

*ALL PHI DATA WILL BE DE-IDENTIFIED WITH A SUBJECT ID. FOR IDENTIFIED INFORMATION, 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.