

# Radiology Cost Estimate Request Form

Abbreviations: For Contrast- with (W) without (W'O), With and without (W/ W'Oo)

<b>Instructions:</b>	
<ul style="list-style-type: none"> <li>Complete the entire form and submit form to <a href="mailto:radiology-research@nyp.org">radiology-research@nyp.org</a> and <a href="mailto:radiology-research@cumc.columbia.edu">radiology-research@cumc.columbia.edu</a></li> <li>Provide a copy of protocol, research plan and imaging manual with this submission. Identify the protocol page numbers pertaining to the Radiology procedures _____</li> </ul>	

<b>Principal Investigator</b>		<b>Phone:</b>	
<b>Fax:</b>		<b>Email:</b>	
<b>Coordinator</b>		<b>Phone:</b>	
<b>Fax:</b>		<b>Email:</b>	
<b>Financial Administrator</b>		<b>Phone:</b>	
<b>Fax:</b>		<b>Email:</b>	

<b>Study Title</b>			
<b>Department initiating Study</b>			
<b>NIH or Industry</b>		<b>Sponsor name</b>	
<b>Estimated number of subjects to be enrolled in study</b>			
<b>Estimated frequency of subject scanning</b>			
<b>Estimated start date</b>		<b>Estimated end date</b>	
<b>IRB# (if not available provide to Radiology when obtained)</b>		<b>Clinical Study Trial # (NCT # on clinicalstrial.gov)</b>	

Please choose all that are required:

Procedure	Contrast	CPT Code(s)	Location	Costs		
Procedure		CPT	Location	NYP Technical	CUMC Professional	CUMC Global
<b>CT</b>						
<input type="checkbox"/> CT Orbits	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> CT Face	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> CT Head/ Brain	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> Neck	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> CT Chest	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> CT Abdomen	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			

Procedure	CPT	Location	NYP Technical	CUMC Professional	CUMC Global
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<input type="checkbox"/> CT Abd & Pelvis	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> CT Pelvis	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
Procedure		CPT	Location	NYP Technical	CUMC Professional	CUMC Global
<input type="checkbox"/> CT upper extremity	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> CT lower extremity	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> Cervical spine	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> Thoracic spine	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> Lumbar spine	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/>	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/>	<input type="checkbox"/> W <input type="checkbox"/> W'O <input type="checkbox"/> W/W'O		<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			

## NUCLEAR MEDICINE and BONE DENSITY

Procedure		CPT	Location	NYP Technical	CUMC Professional	CUMC Global
<input type="checkbox"/> Whole Body Bone Scan			<input type="checkbox"/> NYP			
<input type="checkbox"/> MUGA			<input type="checkbox"/> NYP			
<input type="checkbox"/>			<input type="checkbox"/> NYP			

## MRI

Procedure		CPT	Location	NYP Technical	CUMC Professional	CUMC Global
<input type="checkbox"/> Face, Neck, Orbits			<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> MRI Brain			<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> MRI Chest			<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> MRI Abdomen			<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> MRI Pelvis			<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/>			<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/>			<input type="checkbox"/> NYP <input type="checkbox"/> CUMC			
<input type="checkbox"/> MRI Breast			<input type="checkbox"/> NYP			

## X-RAYS

	1 view	2 view	CPT	Location	NYP Technical	CUMC Professional	CUMC Global
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NYP			
<input type="checkbox"/> Skeletal survey	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NYP			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NYP			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NYP			

## ULTRASOUND

<input type="checkbox"/> Abdomen	<input type="checkbox"/> complete	<input type="checkbox"/> limited		<input type="checkbox"/> NYP			
<input type="checkbox"/>				<input type="checkbox"/> NYP			

## PET Scan and PET/CT

Procedure		CPT	Location	NYP Technical	CUMC Professional	CUMC Global
<input type="checkbox"/> FDG, if required, per dose			<input type="checkbox"/> CUMC			
<input type="checkbox"/> Brain PET			<input type="checkbox"/> CUMC			

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<input type="checkbox"/> PET Whole Body Scan NOT SUITABLE FOR RECIST		<input type="checkbox"/> CUMC			
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<input type="checkbox"/> PET/CT Skull to mid-thigh NOT SUITABLE FOR RECIST		<input type="checkbox"/> CUMC			
<input type="checkbox"/>		<input type="checkbox"/> CUMC			
BIOPSY AND GUIDANCE					
<input type="checkbox"/> CT guidance		<input type="checkbox"/> NYP			
<input type="checkbox"/> Biopsy, location may vary (eg liver)		<input type="checkbox"/> NYP			
<input type="checkbox"/> US guidance		<input type="checkbox"/> NYP			
<input type="checkbox"/> Renal biopsy		<input type="checkbox"/> NYP			
<input type="checkbox"/> Lung biopsy		<input type="checkbox"/> NYP			
<input type="checkbox"/> Lymph node –core needle or excisional LN biopsy		<input type="checkbox"/> NYP			
<input type="checkbox"/> MRI guidance		<input type="checkbox"/> NYP			
<input type="checkbox"/>		<input type="checkbox"/> NYP			
<b>PHANTOM SCANS and SET-UP SCANS</b>			<b>Please Note:</b> •Human Volunteer scans: The cost of the exam will be charged if imaging is performed on a volunteer. •Test scans on human volunteers require that the volunteer be consented under the study protocol.		
<b>Notes: Phantom test scans: the sponsor must provide the phantom object and the cost of the exam will be charged.</b> •Phantom Scan Protocol is required for review.					
Phantom Scan <input type="checkbox"/> Frequency					
Special Calibrated Device (Phantom) <input type="checkbox"/> Frequency Human Volunteer <input type="checkbox"/> Set –up <input type="checkbox"/> (baseline)					
<b>TUMOR ASSESSMENT READS</b>	<input type="checkbox"/> RECIST <input type="checkbox"/> CHESSON <input type="checkbox"/> OTHER				
<b>Data Transmission/ Transfer Cost</b>	<input type="checkbox"/> de-identified CDs / FTP transfers				

Further Instructions and Notes from Dept. of Radiology	Note not all may be required for your study
<b>For NIH / Foundation studies that require RASCAL-PT approval from Radiology</b>	
<ul style="list-style-type: none"> <li>- At the time of Cost Estimate submission and Initial Budget review:</li> <li>- for CUMC Radiology Dept approval - please add Rae Vagg</li> <li>- for NYP Radiology Dept approval – please add Kate Spaziani</li> </ul>	
<b>Prior to the start of the study:</b>	
<ul style="list-style-type: none"> <li>- One month prior to first subject scan For NYP/ CHONY/ CUMC location scans:</li> <li>- Email Directors/ contacts of the Radiological Centers for a Start-up meeting:</li> </ul> IRB #, PI name, (current) approved Protocol, Imaging guidelines/manual, IRB approval, JRSC packet/approval, chart string	
<ul style="list-style-type: none"> <li>- Note: following the review of the imaging guidelines and protocol, a Research Protocol has to be built into the scanner by the Radiologist, hence the request for imaging protocol 1 month prior to first subject scan.</li> </ul>	

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<b>PI Signature</b>		<b>Date Signed</b>	
<b>Date submitted</b>			

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