**IRB Application for Medical Imaging Dose Estimate**

Instructions:

* Complete this form.
* Print, sign and submit by fax to 404.785.0548 or scanned email to [**RadQuality@choa.org**](mailto:RadQuality@choa.org)
* The form will be submitted to the Radiation Safety Officer for dose estimate and approval by the Radiation Safety Committee. Once reviewed, the signed form will be returned to the Principle Investigator or designee.

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| **Study Title/IRB Number** |  |
| **Principle Investigator/Study Coordinator Name** |  |
| **Phone Number**  **Email Address** |  |
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| **Please select the imaging exam requested and answer all questions.** | |
| **Diagnostic X-ray (Includes Fluoroscopy & DEXA)** |  |
| Exam Requested or  Portion of Body to be Imaged |  |
| Is the requested exam Standard of Care\* | Yes No |
| Frequency of Imaging exam |  |
| **CT Scan** |  |
| Exam Requested or  Portion of Body to be Imaged |  |
| Is the requested exam Standard of Care\* | Yes No |
| Frequency of Imaging exam |  |
| **Nuclear Medicine, PET, or SPECT** |  |
| Exam Requested or  Portion of Body to be Imaged |  |
| Is the requested exam Standard of Care\* | Yes No |
| Frequency of Imaging exam |  |
| **\*If the exam is not Standard of Care, please provide details of imaging requested** |  |

**\*\*This section to be completed by RSO\*\***

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| **Radiation Dose Estimate for Requested Exam** |  |
| Radiation Safety Officer Signature/Date |  |