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| **RResearch** **Office** | **Research Radiology and Imaging Proforma** |  |

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| --- | --- | --- | --- |
| RO Reference No:  |  | Radiology Reference No:  |  |
| **Part A: To be completed by Principal Investigator**  |
| Project Title | Association between diet, body composition and physical function in older adults: a pilot study. |
| Lead local investigator |  | Address  |  |
| Tel |  |
| Email |  |
| Co-ordinating Centre |  | Address  |  |
| Tel |  |
| Email |  |
| **Lead Site? YES / NO** |
| **Details of research exposures** |
| **Procedure** | **Standard** | **Additional for research** | **Total** | **Additional information** |
| Main site | Local site | Main site | Local site |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Is an ARSAC certificate required for this study?** | **YES / NO** |
| Signature of Investigator |  | Date |  |

**Part B: To be completed by IRMER Practitioner**

|  |  |
| --- | --- |
| **IRMER Practitioner (X-rays)** |  |
| 1. The Protocol can be adhered to at this site | YES / NO |
| 2. Any additional exposures have been identified in the Ethics application and approved by the Ethics committee | YES / NO |
| 3. The additional exposures are justified having regard to IRMER | YES / NO |
| Protocol accepted? | YES / NO |
| If NO please state reason for rejection: |
| Title |  | Name |  | Surname |  |
| Address |  |
| Tel |  | FAX |  | Email |  |
| Signature of IRMER Practitioner |  | Date |  |

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**Part C: To be completed by Local Medical Physics Expert**

|  |  |
| --- | --- |
| **Medical Physics Expert (X-Rays)** |  |
| 1. The Protocol can be performed at this site within the dose made by the lead MPE | YES / NO |
| 2. The local dose per examination will not exceed the maximum exposure estimated in the REC application | YES / NO |
| 3. The approved PIS accurately reflects the additional radiation and risk to which local participants will be exposed. | YES / NO |
| Protocol accepted? | YES / NO |
| If NO please state reason for rejection: |
| Title |  | Name |  | Surname |  |
| Address |  |
| Tel |  | FAX |  | Email |  |
| Signature of Medical Physics Expert |  | Date |  |

|  |  |
| --- | --- |
| **The dose constraint and / or target dose for IRMER purposes is:** |  |

**Documents to accompany this form**

|  |
| --- |
| Document checklist |
| * Protocol
 |  | Date:  | **YES / NO** |
| * Patient Information Sheet and consent form
 |  | Date:  | **YES / NO** |
| * Copy of dose and risk assessment, completed by main site
 | Date:  | **YES / NO** |
| * IRAS application form
 | **YES / NO** |
| * ARSAC application form
 | **YES / NO** |