**Participating Site IRMER/ARSAC Review Request – Papworth Hospital**

Please complete sections 1 and 2 and attach to an email along with copies of the protocol, R&D form and patient information sheet and send to radiation.approvals@addenbrookes.nhs.uk, ensuring that the email subject contains the word Papworth.

 **Section 1 – Study Details**

**Person(s) whom the form is to be returned to and to be contacted in case of queries?**

*Click to enter name and e-mail address*

**Study Title:** *Click to enter text*

**R&D Reference:** *Click to enter text* **Date of Ethics approval:** *DD/MM/YYYY*

**Sponsor:** *Click to enter text*

**Host Department:** *Click to enter text* **Hospital lead:** *Click to enter text*

 **Section 2 – Clinical Radiation Expert**

**Can the trust adhere to the protocol?** Yes [ ]  No [ ]

*Click to enter text*

**Has any additional exposure been identified in the R&D application?** Yes [ ]  No [ ]

**If so have they been approved by the main REC?** Yes [ ]  No [ ]

 *Click to enter text*

**Are they justified with regard to IRMER?** Yes [ ]  No [ ]

*Click to enter text*

**Please record exposures additional to standard care at your site?**

*Click to enter text*

 **Section 3 – Medical Physics Expert**

**Is a research ARSAC certificate required?** Yes [ ]  No [ ]

**Will the local dose per examination exceed the maximum exposure estimated in the R&D application?** Yes [ ]  No [ ]

*Click to enter text – e.g. number and type of exams, estimated maximum exposure per exam estimated in the R&D application, local dose per exam etc.*

**Can the protocol be performed within the estimated range of dose made by the lead MPE?** Yes [ ]  No [ ]

*Click to enter text – e.g. estimated total dose by lead MPE, estimated total local dose etc.*

**Does the REC approved patient information sheet accurately reflect the additional radiation and risk to which local participants will be exposed?** Yes [ ]  No [ ]

*Click to enter text*

**Recommended constraints and/or target doses for IRMER purposes?**

*Recommend suitable dose constraints/ target doses as appropriate*

**Reviewed by:** *Click to enter text* **Date:** *DD/MM/YYYY*

**Documents attached**

**Protocol:** Yes [ ]  No [ ]

**R&D form:** Yes [ ]  No [ ]

**Patient information sheet:** Yes [ ]  No [ ]