



**ACRIN 6676 / ECOG 2804**  
**Advanced Renal Cell Carcinoma DCE-MRI**  
**MRI Image Transmittal Worksheet**

ACRIN Study **6676**

**PLACE LABEL HERE**

Institution \_\_\_\_\_ Institution No. \_\_\_\_\_

Participant Initials \_\_\_\_\_ Case No. \_\_\_\_\_

If this is a revised or corrected form, please  box.

**INSTRUCTIONS:** Questions 1 thru 5 are completed by the imaging technologist at the time of the MRI examination. Question 6 is to be completed by the site radiologist during image review, and prior to image transmission to the ACRIN Imaging Management Center.

The number of images reported as obtained for each series must correlate with the number of images sent to the ACRIN IMC. All dates are reported as mm-dd-yyyy. This form may be faxed to 215-923-1737.

- 1. Date of study** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (mm-dd-yyyy) [1]
- 1a. Imaging Time Point:** [2]
- Pre-Treatment
  - Post-Treatment
- 2.  Scanner type:** [3]
- 1 GE
  - 2 Siemens
  - 3 Philips
  - 4 Toshiba
  - 5 Other, specify \_\_\_\_\_ [4]

**Sequences Completed:**

For any of the sequences below, if imaging was performed and saved in more than one series, indicate the range of series that pertains to the specific imaging sequence in question. Example: Dynamic gadolinium was run as 60 separate series, each with eight images, beginning at series #14 and ending at series #73. For Q4d enter "14-73" for series #, "8" for number of slices, and "480" for # of images.

- 3. Pre-Gadolinium Axial T1 / T2 Sequences:**
- 3a. Axial T1** [5]
- Yes, Series # \_\_\_\_\_ [6] Number of Images \_\_\_\_\_ [7]
  - No, if no reason: \_\_\_\_\_ [8]
- 3b. Axial T2** [9]
- Yes, Series # \_\_\_\_\_ [10] Number of Images \_\_\_\_\_ [11]
  - No, if no reason: \_\_\_\_\_ [12]

- 4. DCE-MRI Imaging Sequence:**
- T1 mapping:**
- 4a. High Flip** [13]
- Yes, Series # \_\_\_\_\_ [14] # of Slices \_\_\_\_\_ [15] Total # of Images \_\_\_\_\_ [16]
  - No, if no reason: \_\_\_\_\_ [17]
- 4b. Intermediate Flip** [18]
- Yes, Series # \_\_\_\_\_ [19] # of Slices \_\_\_\_\_ [20] Total # of Images \_\_\_\_\_ [21]
  - No, if no reason: \_\_\_\_\_ [22]
- 4c. Low Flip** [23]
- Yes, Series # \_\_\_\_\_ [24] # of Slices \_\_\_\_\_ [25] Total # of Images \_\_\_\_\_ [26]
  - No, if no reason: \_\_\_\_\_ [27]

- DCE Series:**
- 4d. Dynamic Gadolinium Series** [28]
- Yes, Series # \_\_\_\_\_ [29] # of Slices \_\_\_\_\_ [30] Total # of Images \_\_\_\_\_ [31]
  - No, if no reason: \_\_\_\_\_ [32]

- 5. Delayed Post - Gadolinium Imaging Sequences:**
- 5a. Delayed Oblique Coronal (or Sagittal) Post Contrast T1** [33]
- Yes, Series # \_\_\_\_\_ [34] # of Slices \_\_\_\_\_ [35]
  - No, if no reason: \_\_\_\_\_ [36]
- 5b. Delayed Axial Post Contrast T1** [37]
- Yes, Series # \_\_\_\_\_ [38] Number of Images \_\_\_\_\_ [39]
  - No, if no reason: \_\_\_\_\_ [40]



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**6. Screen Capture information (to be filled out by radiologist):**

Fill in slice location (example: "A34.8") for each slice imaged in the DCE-MRI series. If # of slices in DCE-MRI is <12, then indicate 'N/A' for remaining rows. Indicate all slices for which either a tumor or an arterial region-of-interest (ROI) has been chosen. Indicate series and image numbers used for drawing each ROI. Indicate size of ROI (if provided by viewing software) for each ROI drawn. Each image with an ROI must be screen captured with ROI and full annotation (except patient name, if possible) and sent to ACRIN along with entire MRI study. If screen captures cannot be created in DICOM format, please contact Jim Gimpel (215-574-3238) at the ACRIN IMC.

Slice Location	Arterial ROI				Tumor ROI			
	<input checked="" type="checkbox"/> =yes	Series #	Image #	Area (mm <sup>2</sup> )	<input checked="" type="checkbox"/> =yes	Series #	Image #	Area (mm <sup>2</sup> )
1 _____ [41]	<input type="checkbox"/> [42]	[43]	[44]	[45]	<input type="checkbox"/> [46]	[47]	[48]	[49]
2 _____ [50]	<input type="checkbox"/> [51]	[52]	[53]	[54]	<input type="checkbox"/> [55]	[56]	[57]	[58]
3 _____ [59]	<input type="checkbox"/> [60]	[61]	[62]	[63]	<input type="checkbox"/> [64]	[65]	[66]	[67]
4 _____ [68]	<input type="checkbox"/> [69]	[70]	[71]	[72]	<input type="checkbox"/> [73]	[74]	[75]	[76]
5 _____ [77]	<input type="checkbox"/> [78]	[79]	[80]	[81]	<input type="checkbox"/> [82]	[83]	[84]	[85]
6 _____ [86]	<input type="checkbox"/> [87]	[88]	[89]	[90]	<input type="checkbox"/> [91]	[92]	[93]	[94]
7 _____ [95]	<input type="checkbox"/> [96]	[97]	[98]	[99]	<input type="checkbox"/> [100]	[102]	[103]	[103]
8 _____ [104]	<input type="checkbox"/> [105]	[106]	[107]	[108]	<input type="checkbox"/> [109]	[110]	[111]	[112]
9 _____ [113]	<input type="checkbox"/> [114]	[115]	[116]	[117]	<input type="checkbox"/> [118]	[119]	[120]	[121]
10 _____ [122]	<input type="checkbox"/> [123]	[124]	[125]	[126]	<input type="checkbox"/> [127]	[128]	[129]	[130]
11 _____ [131]	<input type="checkbox"/> [132]	[133]	[134]	[135]	<input type="checkbox"/> [136]	[137]	[138]	[139]
12 _____ [140]	<input type="checkbox"/> [141]	[142]	[143]	[144]	<input type="checkbox"/> [145]	[146]	[147]	[148]

**7. Radiologist information:**

7a. Reader ID                      [150]

7b. Radiologist Name \_\_\_\_\_ [151]

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ [152]

**Contact Person Completing Form:**

Name: \_\_\_\_\_ [153]

Phone: \_\_\_\_\_ [154]

Date form completed \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ [155]  
 (mm-dd-yyyy)

6a. Total # of screen saves captured: \_\_\_\_\_ [149]