



**HKU
Med**

**School of Clinical Medicine
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Research Services Request Form

Project Information:

Project Title: _____

Project Principal Investigator/Co I:

_____ / _____

Department/Centre: _____

Name of University: _____

Tel. no. : _____ Fax no. : _____

Email: _____ Ethics Committee Approval: Yes No

Funding Source (RGC/CRCG/ITF or specify): _____

Please attach (1) project summary (2) total no. of subjects and scan hours required (3) references if available

Person of contact / in charge:

Name: _____ Title: _____

Tel. no. : _____ (office) _____ (mobile)

Fax no. : _____ Email: _____

Notes: 1. Charges are according to machine room time.

*2. Please send the completed form with required information to the Unit in person or fax 2817-4013
or email at hkumri@hku.hk.*

Submitted by Project Principal Investigator:

Print name: _____ Title: _____ Date: _____

Notes to PI: In recognition of the support given by the MRI Unit, the PI will indicate in all related publications that the activities were carried out utilizing 1.5T or 3T MRI system, in cooperation and with the support of the MRI Unit of Department of Diagnostic Radiology, The University of Hong Kong.