**PET Imaging Facility Selection Feasibility Questionnaire**

_Thank you for your interest in the New Imaging Dementia - Evidence for Amyloid Scanning (New IDEAS) study. We are looking forward to learning more about the operations of your imaging facility. After reviewing the New IDEAS protocol, please complete the below questionnaire via the link found on the study website. This document serves as resource for facilities to review the questions being asked prior to filling out the survey online. After submission of the questionnaire, the study team will review all responses and provide you with a decision on your participation in the study._

_Sincerely,_

_The New IDEAS Study Team_

**SURVEY MONKEY PAGE 1: PET Facility Profile**

*Please provide the following details about your site:*

<table>
<thead>
<tr>
<th>Name of PET Facility</th>
<th>Type of Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○ Hospital-based facility accredited by a Medicare-approved hospital-accrediting body (i.e. Joint Commission, DNV)</td>
</tr>
<tr>
<td></td>
<td>○ Not hospital-based (physician office or Independent Diagnostic Testing Facility)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is your facility accredited for brain PET?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ American College of Radiology (ACR)</td>
</tr>
<tr>
<td></td>
<td>☐ Intersocietal Accreditation Commission (IAC)</td>
</tr>
<tr>
<td></td>
<td>☐ RadSite</td>
</tr>
<tr>
<td></td>
<td>○ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is your facility eligible to bill for Medicare services?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did your facility participate in the original IDEAS Study?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many Brain PET with F-18 fluorodeoxyglucose (FDG) studies did your facility perform during the past 12 months?</th>
<th>Less than 25</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26 - 50</td>
</tr>
<tr>
<td></td>
<td>51 – 75</td>
</tr>
<tr>
<td></td>
<td>76 or more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City/State/Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone (Office)</th>
<th></th>
</tr>
</thead>
</table>
**SURVEY MONKEY PAGE 2: Research Staff and Co-Investigators:**

*Please provide the following information about your research and recruitment experiences:*

<table>
<thead>
<tr>
<th>Name of Primary reading physician (i.e. radiologist or nuclear medicine specialist) to read participant scans:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address of primary reading physician:</td>
<td></td>
</tr>
</tbody>
</table>
| Are they board certified? | o Yes  
  o No |
| If yes, Please check all that apply | o American Board of Radiology (Diagnostic Radiology)  
  o American Board of Radiology (Nuclear Radiology)  
  o American Osteopathic Board of Radiology (Diagnostic Radiology)  
  o American Board of Nuclear Medicine  
  o American Osteopathic Board of Nuclear Medicine |
| Total number of board-certified physicians you plan to have at your site that will read participant scans. |  |
| Which, if any, vendor-specific training has your site’s radiologists completed for interpretation of amyloid PET images? (check all that apply) | o Amyvid™ (florbetapir)  
  o Neuraceq™ (florbetaben)  
  o Vizamyl™ (flutemetamol) |
| Does the staff have experience with EDC/eCRFs | o Yes  
  o No |
| Does your facility currently have TRIAD installation in use for transmitting images to the American College of Radiology? | o Yes  
  o No |
| Do you have staff who speak Spanish to assist with PET Scan procedures? | o Yes  
  o No |
SURVEY MONKEY PAGE 3: PET Scanner Information:
*Provide information for each PET scanner that will be used in the New IDEAS-Study:*
*Note: Only scanners accredited specifically for brain PET can be used in IDEAS Study. Additionally, only full-ring BGO, GSO, LSO or LYSO PET scanners are eligible to participate; partial-ring and dedicated NaI systems are NOT eligible for use in the New IDEAS Study.*

<table>
<thead>
<tr>
<th>Scanner Name</th>
<th>Manufacturer</th>
<th>Model</th>
<th>Fixed or Mobile?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fixed ☐</td>
</tr>
</tbody>
</table>

SURVEY MONKEY PAGE 4: Contracts and Finance
*Please answer the following questions about Administrative Processes at your site:*

<table>
<thead>
<tr>
<th>Does your facility have a legal person to review the Business Associate Agreement?</th>
<th>o Yes</th>
<th>o No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, name and title of contracts person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email Address of contracts person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the average amount of time your institution needs to review and finalize contracts?</td>
<td>o 2 weeks or less</td>
<td>o 2-4 weeks</td>
</tr>
<tr>
<td>Participating facilities will not receive additional funding outside standard reimbursement from CMS for participating. Is this a barrier to your site’s participation?</td>
<td>o Yes</td>
<td>o No</td>
</tr>
</tbody>
</table>

SURVEY MONKEY PAGE 5: Referrals and Stakeholder Relationships
*Please answer the following questions about additional community relationships:*

<table>
<thead>
<tr>
<th>Has your facility discussed this study with or identified a dementia practice who will refer study participants to you?</th>
<th>o Yes</th>
<th>o No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, Please provide the name of the practice.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Do you have any colleagues from the same or other organization who might be interested in participating in this study? | o Yes  
o No |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
</tr>
<tr>
<td>Organization/Facility:</td>
<td></td>
</tr>
</tbody>
</table>
| Would they serve as a Referring Physician Site or PET Facility? | o Referring Physician Site  
o PET Facility |

**Confidentiality and Assurance Statement**

My signature below affirms that all the information given above is correct to the best of my knowledge. I shall hold any and all information received from the ACR in future in relation to any clinical trial as confidential. I agree to not disseminate or discuss my responses with anyone outside of my organization.

| Name of Person Completing this Form: | |
| Professional Title: | |
| Signature: | |
| Date: | |
| Email Address: | |