PHONE: 1-877-972-9247

ADDRESS: 205 Park Central East #516, Springfield, MO 65806

EMAIL: amber@etr247.com

CONFIDENCE IN QUALITY OF REPORT

PATIENT NAME	MRN #	DATE OF SERVICE
READING PHYSCIAN	MODALITY	
REQUESTED BY		

1-4 scale definitions:

1	2	3	4

1. Agreement in principle but would have worded differently.
2. Miss by radiologist, however would not have resulted in a significantly different treatment or outcome.
3. Miss by radiologist requesting review of images with QA department and reading radiologist.
4. Miss by radiologist which results in a different patient outcome or treatment.

REQUEST OVERVIEW OF RADIOLOGY REPORT

Y	N

REASON FOR REQUEST

_____

_____

_____

REQUEST ADDENDUM TO REPORT

Y	N

_____

QA RADIOLOGIST FINDINGS

_____

_____

_____

1	2	3	4