

Quality Assurance & Quality Control

CONFIRMATION OF RESULTS

Confirmation and confirmation of the results of at least 4 randomly selected echocardiography studies will be presented at each quarterly staff Quality Assurance meeting for review and discussion.

- Quality Assurance procedures will also be utilized to review and confirm echocardiography results in order to maintain an expected level of accuracy in our diagnostic studies. Quarterly Quality Assurance and Quality Control procedures will include the review of case quality.
- A random selection of selected examinations will be compared to Catheterization, MRA, CTA, Angiography, and/or Intraoperative reports as they are available.
- Confirmation of results will be performed by the Technical Director or his/her designee.
- Exams interpreted by the Medical Director and Medical Staff will be randomly selected for review and second opinion, in order to ensure accuracy in reporting and results. This will be dictated by the Technical Director.

The findings of the confirmations will be disseminated to Medical Staff in accordance with the Quality Assurance Discrepancies Policy.

- The findings of the confirmations will also be reviewed by the Medical and Technical staff members during the quarterly departmental Quality Assurance meetings. This will allow for direction and recommendations for improvement of technical imaging and/or physician interpretations.
- A review of the echocardiography quality control study completion, completion, and compliance with the departmental policies will be made at the quarterly departmental

QUALITY ASSURANCE DEPARTMENT MEETINGS:

- Echocardiography departmental conferences will be held quarterly in order to monitor technical measurements and quality assurance meetings will allow for quality assurance review and review, in-house presentation of staff members and the results of quality assurance studies.
- Attendance of each Medical and Technical staff member is required at fifty percent of the meetings, each calendar year.

- The correlation and confirmation of results of randomly selected echocardiography studies will be presented for review and discussion as directed in the written departmental policy.

Any additional findings or issues will be presented on the agenda for discussion at the next meeting. The meeting agendas and the minutes of the data presented and any actions or recommendations implemented. This information will be utilized to improve patient care and the accuracy of our echocardiography examination results.

- Ultimately, Quality Assurance and Quality Control procedures will be utilized to improve the standard of care at our facility.

REPORT REVIEW AND COMPLETENESS

- The Technical Director will supervise quarterly reviews of the echocardiography reports to evaluate for timeliness and the completeness of the interpretations and final reports.
- Report reviews will consist of a minimum of ten studies.
- Report reviews will assess the timeliness of the dictations and final reports, as well as the accuracy of the results.
- Report reviews will assess the completeness of the final reports with the following: dictation, including report header and patient demographic information, basic patient clinical data (height, weight, BSA, blood pressure), exam indication, study measurement data, Left Ventricular Size and Function, Right Ventricular Size and Function, Valve Structure and Function, Valvular Regurgitation, Cardiac Chamber Size, Great Vessels, Pericardium.
- The results of the reviews will be disseminated to the Medical Director and results will be discussed with Medical and Technical staff members during quarterly departmental Quality Assurance meetings.
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QUALITY ASSURANCE DISCREPANCIES:

- The Technical Director will perform Quality Assurance Review (including variability in measurements, measurements, and standard deviations) and Staff will be informed of the results of the quality assurance measurements and the results of the quality assurance studies.

- If discrepancies are noted during the quality assurance reviews, the Medical Director will alert the technical staff and evaluate the reason for the discrepancy and will work with the technical staff to resolve any discrepancies affecting quality assurance matters.
- The Medical Director will refer any concerns to the technical staff in order to correct any quality assurance procedures and to allow for improvement of exam quality within the department.

EQUIPMENT AND INSTRUMENT QUALITY CONTROL

PREVENTATIVE MAINTENANCE PROCEDURES

- Preventative maintenance procedures will be used to assure that instruments and diagnostic equipment used for diagnostic testing are maintained in good operating condition.
- Quality assurance in the ultrasound lab requires documentation of proper equipment maintenance and safety measures. Quality Assurance procedures will be used to help ensure that the equipment utilized by our facility meets or exceeds expected standards. This includes but is not limited to:
 - All ultrasound equipment will be maintained under a service contract with **YOUR SERVICE PROVIDER**.
 - Equipment will receive preventative maintenance (PM) service on the **YOUR EQUIPMENT TYPE** ultrasound units every six months according to the guidelines and specifications recommended by the equipment manufacturer, **YOUR EQUIPMENT MANUFACTURER**. Calibration with use of an ultrasound phantom will be performed and documented for each Preventative Maintenance service.

SAFETY INSPECTION AND GENERAL MAINTENANCE OF INSTRUMENTS AND TRANSDUCERS

- The sonographer will perform routine inspection of imaging equipment including safety inspection of B-mode, Doppler, and color Doppler equipment. This will be performed routinely as scheduling permits, at a minimum of once monthly. This will be performed by rinsing filters and allowing them to air dry. This will be documented in the medical equipment log.
- The sonographer will clean transducers with antiseptics and viral cleaning agents on each patient and will take care to clean transducer cables and cords and/or as needed with each patient encounter.
- The sonographer will inspect transducers for any damage. If there is any damage or if there are any concerns, please refer to transducer cleaning policy for more details.

- Any damage or malfunction of ultrasound equipment and/or transducers will be immediately disseminated to the Medical Director and use of equipment will be discontinued until a solution is reached or replacement of malfunctioning damaged equipment is performed. Documentation of equipment malfunction or damage will be maintained in the medical equipment log.
- All accessible components of ultrasound equipment (including accessible filters) must be cleaned on a routine basis (a minimum of once monthly), with documentation maintained on the medical equipment logs.
- All ultrasound equipment, both imaging and non-imaging must be visually evaluated for electrical safety once per month, at a minimum of once monthly, and checking for any electrical safety issues must be completed and documented in the Medical Equipment Log.
- All safety and maintenance records are located in the medical equipment log section of the Quality Assurance manual.

APPROPRIATE USE CRITERIA

The purpose of the ASE Guidelines is to ensure appropriate use of examination indications for TTE. The ASE Guidelines are based on a consensus process and are subject to change. The ASE will perform quarterly reviews of the exam indications. Scoring will take place based upon the ASE guidelines for Appropriate Use Criteria and documentation of the results will be maintained within the department and disseminated to the Medical and Technical Staff. Suggestions for improvement will be made by the Medical Director based upon the findings of the review.

Scoring will be based on the following criteria: U (Uncertain), A (Appropriate), I (Inappropriate), and G (Generally Acceptable). The ASE will perform quarterly reviews of the exam indications.

4 to 6 - Uncertain for specific indication (test may be generally acceptable and may be a reasonable approach for the indication). Uncertainty also implies that more research and/or patient information is needed to classify the indication definitively.

1 to 3 - Inappropriate test for that indication (test is not generally acceptable and is not a reasonable approach to the indication).

Appropriate Use Guidelines for Transthoracic Echocardiography

Suspected Cardiac Etiology—General With TTE

1. Symptoms or conditions potentially related to suspected cardiac etiology including but not limited to chest pain, shortness of breath, palpitations, TIA, stroke, or peripheral embolic event A (8)
2. Prior testing that is concerning for heart disease or structural abnormality including but not limited to chest X-ray, baseline ECG/ECG, stress echocardiogram, ECG, telemetry, or stress test A (8)
3. Myocardial infarction With TTE
4. Re-evaluation of a patient with prior echocardiogram showing heart disease I (2)
5. Re-evaluation of a patient with prior echocardiogram showing normal heart disease I (2)
6. Re-evaluation of a patient with prior echocardiogram showing normal heart disease I (2)
7. Lightheadedness/Presyncope/Syncope With TTE

7. Clinical symptoms or signs consistent with a cardiac diagnosis known to cause lightheadedness/presyncope/syncope (including but not limited to aortic stenosis, hypertrophic cardiomyopathy, or HF) A (8)

8. Lightheadedness/presyncope when there are no other symptoms or signs of heart disease I (2)

9. Syncope when there are no other symptoms or signs of heart disease A (7)

Evaluation of Ventricular Function With TTE

10. Evaluation of ventricular function in a patient with no symptoms or signs of heart disease I (2)

11. Evaluation of ventricular function in a patient with no symptoms or signs of heart disease I (2)

12. Evaluation of LV function with prior ventricular function evaluation showing normal function (e.g., prior echocardiogram, CT, SPECT/MP, CMR) in patients in whom there has been no change in clinical status or cardiac exam I (1)

Peroperative Evaluation With TTE

13. Routine surveillance (>1 y) of moderate or severe valvular stenosis without a change in clinical status or cardiac exam I (1)

14. Routine surveillance (>1 y) of moderate or severe valvular regurgitation without a change in clinical status or cardiac exam I (1)

15. Evaluation of suspected pulmonary hypertension including evaluation of right ventricular function and estimated pulmonary artery pressure A (8)

16. Routine surveillance (>1 y) of known pulmonary hypertension without change in clinical status or cardiac exam I (3)

17. Routine surveillance (>1 y) of known pulmonary hypertension without change in clinical status or cardiac exam I (3)

18. Routine surveillance (>1 y) of known pulmonary hypertension without change in clinical status or cardiac exam I (3)

19. Routine surveillance (>1 y) of known pulmonary hypertension without change in clinical status or cardiac exam I (3)

20. Assessment of volume status in a critically ill patient U (5)

21. Myocardial Ischemia/Infarction With TTE

22. Acute chest pain with suspected MI and non-diagnostic ECG when showing echocardiogram can be performed during patient care

23. Evaluation of ventricular function following ACS A (8)

24. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

25. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

26. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

27. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

28. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

29. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

30. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

31. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

32. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

33. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

34. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

35. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

36. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

37. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

38. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

39. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

40. Re-evaluation of ventricular function following ACS during recovery phase when results will guide therapy A (8)

- 47. Routine surveillance (>3y after valve implantation) of prosthetic valve if no known or suspected valve dysfunction A (7)
- 48. Evaluation of prosthetic valve with suspected dysfunction or change in clinical status or cardiac exam U (4)
- 49. Routine surveillance (>3y after valve implantation) of prosthetic valve if no known or suspected valve dysfunction A (7)
- 50. Evaluation of prosthetic valve with suspected dysfunction or change in clinical status or cardiac exam U (4)
- 51. Re-evaluation of known prosthetic valve dysfunction when it would change management or therapy U (4)
- 52. Routine surveillance (>1y) of infective endocarditis without a change in clinical status or cardiac exam U (4)
- 53. Routine surveillance (>1y) of infective endocarditis with a change in clinical status or cardiac exam U (4)
- 54. Routine surveillance (>1y) of infective endocarditis with a change in clinical status or cardiac exam U (4)
- 55. Re-evaluation of infective endocarditis at high risk for progression or complication or with a change in clinical status or cardiac exam A (8)
- 56. Routine surveillance of uncomplicated infective endocarditis when no change in management is contemplated U (4)
- 57. Routine surveillance (>1y) of infective endocarditis when no change in management is contemplated U (4)
- 58. Routine surveillance (>1y) of infective endocarditis when no change in management is contemplated U (4)
- 59. Routine surveillance (>1y) of infective endocarditis when no change in management is contemplated U (4)
- 60. Routine surveillance (>1y) of infective endocarditis when no change in management is contemplated U (4)
- 61. Routine surveillance (>1y) of infective endocarditis when no change in management is contemplated U (4)
- 62. Guidance of percutaneous noncoronary cardiac procedures including, not limited to pericardiocentesis, septal ablation, or right ventricular biopsy A (8)
- 63. Evaluation of the ascending aorta in the setting of a known or suspected connective tissue disease or genetic condition that predisposes to aortic aneurysm or dissection (e.g., Marfan syndrome) U (8)
- 64. Re-evaluation of known ascending aortic aneurysm or dissection in the setting of a change in clinical status or cardiac exam U (4)
- 65. Re-evaluation of known ascending aortic aneurysm or dissection in the setting of a change in clinical status or cardiac exam U (4)
- 66. Re-evaluation of known ascending aortic aneurysm or dissection in the setting of a change in clinical status or cardiac exam U (4)
- 67. Initial evaluation of suspected hypertensive heart disease A (8)
- 68. Routine evaluation of systemic hypertension without symptoms or signs of hypertensive heart disease U (4)
- 69. Re-evaluation of known hypertensive heart disease without a change in clinical status or cardiac exam U (4)
- 70. Initial evaluation of known or suspected HF (systolic or diastolic) based on symptoms, signs, or cardiac exam U (4)
- 71. Initial evaluation of known or suspected HF (systolic or diastolic) based on symptoms, signs, or cardiac exam U (4)
- 72. Initial evaluation of known or suspected HF (systolic or diastolic) based on symptoms, signs, or cardiac exam U (4)
- 73. Initial evaluation of known or suspected HF (systolic or diastolic) based on symptoms, signs, or cardiac exam U (4)
- 74. Routine surveillance (<1 y) of HF (systolic or diastolic) when there is no change in clinical status or cardiac exam I (2)
- 75. Routine surveillance (>1 y) of HF (systolic or diastolic) when there is no change in clinical status or cardiac exam U (8)
- 76. Routine Evaluation (Annual) of Pacemaker, ICD, or CRT U (8)
- 77. Routine Evaluation (Annual) of Pacemaker, ICD, or CRT U (8)
- 78. Routine Evaluation (Annual) of Pacemaker, ICD, or CRT U (8)
- 79. Routine surveillance (<1 y) of implanted device without a change in clinical status or cardiac exam I (1)
- 80. Routine surveillance (>1 y) of implanted device without a change in clinical status or cardiac exam I (3)

- 81. To determine cardiac function of a patient with aortic valve disease U (4)
- 82. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 83. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 84. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 85. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 86. Initial evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 87. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 88. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 89. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 90. Re-evaluation of known or suspected cardiomyopathy (e.g., restrictive, infiltrative, dilated, hypertrophic or genetic cardiomyopathy) A (8)
- 91. Baseline and serial re-evaluations in a patient undergoing therapy with cardiotoxic agents A (8)
- 92. Initial evaluation of known or suspected adult congenital heart disease U (8)
- 93. Known adult congenital heart disease with a change in clinical status or cardiac exam U (4)
- 94. Re-evaluation of known or suspected adult congenital heart disease A (8)
- 95. Re-evaluation of known or suspected adult congenital heart disease following complete repair U (8)
- 96. Re-evaluation of known or suspected adult congenital heart disease following complete repair U (8)
- 97. Routine surveillance (<1 y) of adult congenital heart disease following complete repair U (8)
- 98. Routine surveillance (<1 y) of adult congenital heart disease following complete repair U (8)
- 99. Routine surveillance (<1 y) of adult congenital heart disease following complete repair U (8)
- 100. Routine surveillance (<1 y) of adult congenital heart disease following complete repair U (8)

ACC/AHA/ASNC/HFSA/HRS/SCAI/SCCM/SOCC/SOMR 2011 Appropriate Use Criteria for Echocardiography
 114 Douglas et al. Journal of the American Society of Echocardiography, March 2011

SAMPLE ONLY

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APPROPRIATE USE

REVIEWER: _____

Scoring Instructions: 4 - Appropriate; 3 - Inappropriate; 1/2 - Uncertain
 7 to 9 - Appropriate test (medically indicated for a given condition) and is a reasonable approach for the condition
 4 to 6 - Uncertain for specific indication (may be appropriate and reasonable approach for the condition, but further study also implies that more research and/or patient information is needed to classify the indication definitively)
 1 to 3 - Inappropriate test for that indication (test is not generally acceptable and is not a reasonable approach for the indication)
 See Appropriate Use Criteria Policy for Detailed Evaluation by Diagnosis/Indication - Score A(9) highest; I (1) lowest

SAMPLE ONLY

	PATIENT	DOB	ICD-8/Indication	Score	NOTE
1.					
2.	SAMPLE ONLY				
3.					
4.					
5.					
6.	SAMPLE ONLY				
7.					
8.					
9.					
10.					
11.	SAMPLE ONLY				
12.					
13.					
14.					

Echocardiogram Correlation

Sonographer:	Exam Date:	Exam #:
Study Date:	Study Location:	Study ID:
Patient Name:	DOB:	
ECHO Type:	Referring Physician:	
EFX:	PRP:	
Requestor (a) (location/arrhythmia):		
Damaged Wall Sequence (location/arrhythmia):		
Stress:		
Other:		
CORRELATION / RESULT		
ECG/ECG Interpretation:	Date:	
EFX:	PRP:	
Requestor (a) (location/arrhythmia):		
Damaged Wall Sequence (location/arrhythmia):		
Stress:		
Other:		
Nuclear/Stress Result:	Date:	
Damaged Wall Sequence (location/arrhythmia):		
EFX:	PRP:	
Other:		
HR/CT Result:	Date:	
Damaged Wall Sequence (location/arrhythmia):		
Stress:		
EFX:	PRP:	
Other:		
CAT/PSurgical Result:	Date:	
EFX:	PRP:	
Requestor (a) (location/arrhythmia):		
Damaged Wall Sequence (location/arrhythmia):		
Stress:		
Other:		

ECHOCARDIOGRAPHY REPORT

Location: Office Location
Patient Name: Last, First, MI
Referring Physician: M.D.
Exam Date: 1/17/2011
Exam Time: 15:00
Study: Transthoracic Echocardiography
Indications: Heart failure
DP Exam #: 132/11

LA Measurements		RA Measurements	
LA Size (cm)	4.2	RA Size (cm)	4.5
LA Volume (ml)	150	RA Volume (ml)	150
LA Aortic Annulus (cm)	3.5	RA Aortic Annulus (cm)	3.5
LA Mitral Annulus (cm)	3.5	RA Mitral Annulus (cm)	3.5
LA Tricuspid Annulus (cm)	3.5	RA Tricuspid Annulus (cm)	3.5
LA Pulmonary Annulus (cm)	3.5	RA Pulmonary Annulus (cm)	3.5
LA Aortic Root (cm)	3.5	RA Aortic Root (cm)	3.5
LA Mitral Valve (cm)	3.5	RA Mitral Valve (cm)	3.5
LA Tricuspid Valve (cm)	3.5	RA Tricuspid Valve (cm)	3.5
LA Pulmonary Valve (cm)	3.5	RA Pulmonary Valve (cm)	3.5
LA Aortic Valve (cm)	3.5	RA Aortic Valve (cm)	3.5
LA Mitral Valve Area (cm ²)	4.0	RA Mitral Valve Area (cm ²)	4.0
LA Tricuspid Valve Area (cm ²)	4.0	RA Tricuspid Valve Area (cm ²)	4.0
LA Pulmonary Valve Area (cm ²)	4.0	RA Pulmonary Valve Area (cm ²)	4.0
LA Aortic Valve Area (cm ²)	4.0	RA Aortic Valve Area (cm ²)	4.0

This is a good study technically.
 Patient appeared to be normal sinus rhythm throughout the exam.
 The aortic valve appeared to be normal in size and function. There was no evidence of aortic stenosis or aortic regurgitation. The mitral valve appeared to be normal in size and function. There was no evidence of mitral stenosis or mitral regurgitation. The tricuspid valve appeared to be normal in size and function. There was no evidence of tricuspid stenosis or tricuspid regurgitation. The pulmonary valve appeared to be normal in size and function. There was no evidence of pulmonary stenosis or pulmonary regurgitation. The aortic root appeared to be normal in size and function. There was no evidence of aortic root dilation. The left ventricle appeared to be normal in size and function. There was no evidence of left ventricular hypertrophy or left ventricular dilation. The right ventricle appeared to be normal in size and function. There was no evidence of right ventricular hypertrophy or right ventricular dilation.

The tricuspid valve is normal in structure and normal in function, with normal excursion. The RVSP was 22mmHg, with pulmonary hypertension of a slight degree. There was evidence on Doppler assessment of mild tricuspid regurgitation. The left ventricle is normal in size and function. The left ventricular wall is normal in thickness and motion. The left atrium is normal in size and function. The right atrium is normal in size and function. The right ventricle is normal in size, volume and function.

IMPRESSION:
 Normal sinus rhythm.
 Mild degree of mitral regurgitation, but no significant increase in pressure of the pulmonary vasculature.
 Mild degree of concentric Left ventricular hypertrophy. No abnormal wall motion was noted.
 Moderate degree of tricuspid regurgitation with mild pulmonary hypertension. No significant mitral regurgitation noted.
 The ejection fraction of the left ventricle is normal (65%).
 No chordal or leaflet abnormalities were noted. There was no evidence of aortic or pulmonary stenosis or regurgitation.
 There was a mild degree of left ventricular diastolic restriction secondary to left ventricular hypertrophy.
 The remaining components of this echocardiogram appear to be within normal limits.

Thank you for allowing us to participate in the care of your patient.

Physician: M.D.

ICAEL Case Study Log

ADULT TRANSTHORACIC ECHOCARDIOGRAPHY				
ICASE STUDY ID	PATIENT NAME	PHYSICIAN/PROVIDER	DATE	PATHOLOGY
<i>Abnormal:</i>				Aortic Stenosis
<i>Abnormal:</i>				Aortic Stenosis
<i>Abnormal:</i>				Aortic Stenosis
<i>Abnormal:</i>				Aortic Stenosis
<i>Abnormal:</i>				LV Dysfunction
<i>Abnormal:</i>				LV Dysfunction
<i>Abnormal:</i>				LV Dysfunction
<i>Abnormal:</i>				LV Dysfunction

Aortic Stenosis: Must be $>2m/s$ and must include peak/off transducer with attempts at aortic, right parasternal and suprasternal notch views. Φ ur

LV Dysfunction Cases: Must be regional wall motion abnormalities, **NOT** global or diastolic dysfunction.

Be sure to include your BEST work. Be sure that views are not frozen/locked. Include your studies on CD/DVD and be sure to provide a copy of the final report, as well as the technological worksheet if one is completed.

Echocardiography Correlation Log

Date	Patient Name /DOB	Exam Performed	Correlation To	Results Conf:
				Y/H
SAMPLE ONLY				Y/H
SAMPLE ONLY				Y/H
SAMPLE ONLY				Y/H
SAMPLE ONLY				Y/H
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SAMPLE ONLY				Y/H

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Technologist / Sonographer Exam Review

Type of No. _____

Technologist: _____

Reviewer: _____ Date of Review: _____

Criteria	Study #1	Study #2	Study #3
Type of _____			
Adherence to protocol			
Exam is complete and thorough			
Waveform _____ (CV, Doppler, etc.)			
Image quality (if applicable)			
Overall technical quality (system settings, accurate measurements and angle technique)			

Criteria Score: 8=Excellent 7=Good 6=Fair 5=2 4=Some Deficiencies 3=Unsatisfactory 2=4

Review Comments:

Study #1: _____

Study #2: _____

Study #3: _____

Physician / Final Report Review

SAMPLE ONLY

Reviewer : _____ Date of Review _____

	Study # 1	Study #2	Study #3
Interpretation			

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Interpretation Scoring: No Discrepancies=1 | Minor Discrepancies=2 | Major Discrepancies=3

Report Scoring: Accurate/Complete=1 | Minor Inconsistencies=2 | Major Inconsistencies=3

SAMPLE ONLY

Study #1: _____

SAMPLE ONLY

Study #2: _____

Preliminary/STAT Results

SAMPLE ONLY

Time: _____

Patient Name: _____

Exam Performed: _____

SAMPLE ONLY

Result called by: _____

Date: _____

Summary of Results: _____

SAMPLE ONLY

SAMPLE ONLY

TIMELINESS/COMPLETENESS OF REPORTS

REVIEWER: _____

	PATIENT	CLASS	TYPE	FINAL	REF	ME	PERI	AO
					PHYS	ASS	102	S2
1.						Y/N		
2.						Y/N		
3.						Y/N		
4.						N		
5.						Y/N		
6.						Y/N		
7.						Y/N		
8.						N		
9.						Y/N		
10.						Y/N		

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