3-Hole 1/4 1 3/8 c-to-c

Hilo Medical Center
We Care for Our Community

RADIOLOGY PRELIMINARY REPORT

Patient Name: _____

Date of Birth: _____

MRN: _____

Date of Exam: _____ Time: _____

Type of Exam: _____

REPORT DELIVERED TO THE ER:

DATE: _____ TIME: _____ INITIALS: _____

EMERGENCY DEPARTMENT PHYSICIAN ☐ **RADIOLOGIST** ☐ **OTHER** ☐ **INITIAL INTERPRETATION:**

Date: _____ Time: _____

FINDINGS: ☐ Normal ☐ Abnormal

COMMENTS:

Physician Signature: _____

RADIOLOGIST REVIEW OF FILM(S): NOTE – "SIGNIFICANT FINDINGS INDICATE A LIFE OR DEATH SITUATION"

☐ Normal ☐ Abnormal ☐ Significant findings – ER notified (date/time): _____

COMMENTS:

☐ Agree with ER interpretation ☐ Disagree with ER interpretation

Radiologist Signature/Date/Time: _____

EMERGENCY DEPARTMENT PHYSICIAN FOLLOW-UP TO RADIOLOGIST'S REVIEW:

☐ Not Significant; no further action needed Notification made to ☐ Patient's Primary MD ☐ the patient

COMMENTS:

Completion, review and follow-up by: (ER MD Signature/Date/Time): _____

WHITE: ER / MEDICAL RECORD **YELLOW: ER QA** **PINK: Imaging QA**

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