

Components of a Radiology Report

1. Demographics

- a. The facility or location where the study was performed.
- b. Name of patient and another identifier.
- c. Patient's date of birth or age.
- d. Patient's gender.
- e. Name(s) of referring physician(s) or other health care provider(s). Name of patient if self-referred (a patient who seeks medical care without a physician referral).
- f. Name or type of examination.
- g. Date of the examination.
- h. Time of the examination, if relevant (e.g., for patients who are likely to have more than one of a given examination per day).

2. Relevant clinical information

3. Body of the report

a. Procedures and materials

Include a description of the studies and/or procedures performed and any contrast media and/or radiopharmaceuticals (including specific administered activities, concentration, volume, and route of administration when applicable), medications, catheters, or devices used, if not recorded elsewhere.

b. Findings

Include anatomic, pathologic, and radiologic terminology to describe the findings.

c. Potential limitations

Identify factors that may compromise the sensitivity and specificity of the examination.

d. Clinical issues

Address or answer any specific clinical questions. If there are factors that prevent answering of the clinical question, this should be stated explicitly.

e. Comparison studies and reports

Comparison with relevant examinations and reports should be part of the radiologic consultation and report when appropriate and available.

4. Impression (conclusion or diagnosis)

a. Unless the report is brief, each report should contain an "impression" section.

b. A specific diagnosis should be given when possible.

c. A differential diagnosis should be rendered when appropriate.

d. Follow-up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate.