Please note: Fields within bold borders are required for both "green" and "gold" participants. Fields outside bold borders should be entered by "gold" participants only.

1. Facility number	(auto filled)	
2. Year	_____	
3. Setting		
Number of admissions during the previous calendar year	_____	☐ Not applicable (Facility is not a hospital)
Case mix index	_____	
4. Volume	**Number of procedures during the previous calendar year**	**OR Not applicable (Facility does not perform the procedure)**
Mammography	_____	☐ Not applicable
Stereotactic breast biopsy	_____	☐ Not applicable
Breast ultrasound	_____	☐ Not applicable
Ultrasound (excluding breast ultrasound)	_____	☐ Not applicable
MRI without contrast	_____	☐ Not applicable
MRI with contrast	_____	
MRI with and without contrast	_____	
CT without contrast	_____	☐ Not applicable
CT with contrast	_____	
CT with and without contrast	_____	
Nuclear medicine	_____	☐ Not applicable
PET	_____	☐ Not applicable
PET / CT	_____	☐ Not applicable
Radiography	_____	☐ Not applicable
Interventional (including IR Fluoroscopy)	_____	☐ Not applicable
Fluoroscopy (excluding IR)	_____	☐ Not applicable
Bone densitometry	_____	☐ Not applicable

5. Personnel	**Number of personnel**
Radiologists	_____
FTE radiologists	_____
Fellows	_____
Residents	_____
Radiologist assistants / Radiology PA's	_____
NP's	_____
RN's / LPN's	_____
Technologists	_____
FTE technologists	_____
Technologist assistants	_____
CT certification required for technologists?	O No O Yes
MR certification required for technologists?	O No O Yes
ACLS certification or equivalent required for physicians performing interventional procedures?	O No O Yes O Facility does not perform interventional procedures

6. MRI incidents	**Number of incidents during the previous calendar year**
Magnet incidents	_____
Cases of NSF	_____
7. Other incidents	**Number of incidents during the previous calendar year**
Attended falls in radiology department	_____
Unattended falls in radiology department	_____
Deaths in radiology department	_____
Code blues in radiology department	_____
Nosocomial infections in radiology department	_____
Wrong exam	_____
Wrong patient	_____

Wrong site	_____
8. Structural measures	
Electronic report access 24/7	O No O Yes
Radiologist consult required before ordering image	O No O Yes, indicate all that apply: ☐ IR ☐ Neuro IR ☐ MR with contrast ☐ CT with contrast ☐ Stat ☐ Other
Decision support (appropriateness criteria, etc.) available on order-entry system	O No O Yes
Patient satisfaction survey specific to radiology in regular use	O No O Yes, indicate all that apply: ☐ Inpatient ☐ Outpatient

9. Protocols	**Indicate whether a written protocol exists for the event or condition.**
Management of risk of nephrotoxicity	O No O Yes
Pregnancy screening	O No O Yes
Allergy screening	O No O Yes
[1]Communication of critical results	O No O Yes
[1]Communication of critical tests	O No O Yes
Infection control	O No O Yes
MR safety screening	O No O Yes

10. Equipment type	**Number of ACR accredited units**	**Number of units pending ACR accreditation**	**Total number of units**
Mammography	_____	_____	_____
Stereotactic breast biopsy	_____	_____	_____
Breast ultrasound (not used for other ultrasound procedures)	_____	_____	_____
Ultrasound (not used exclusively for breast ultrasound)	_____	_____	_____
MRI	_____	_____	_____
CT	_____	_____	_____
Nuclear medicine	_____	_____	_____
PET	_____	_____	_____
PET / CT	_____	_____	_____
Radiography			_____
Interventional (including IR Fluoroscopy)			_____
Fluoroscopy (excluding IR)			_____
Bone densitometry			_____

11. Name of person who completed this paper form	
Last name	_____
First name	_____

[1] Required for Joint Commission National Patient Safety Goals accreditation

Please note: Fields within bold borders are required for both "green" and "gold" participants. Fields outside bold borders should be entered by "gold" participants only.

1. Facility number	(auto filled)
2. Month / year to which form applies	____/_____ (mm/yyyy)
3. Process measures	
Patient wait time (outpatient)	Mean time in minutes / Median time in minutes
Radiography	_____ / _____
Ultrasound (excluding breast ultrasound)	_____ / _____
MRI without oral contrast	_____ / _____
CT without oral contrast	_____ / _____
PET	_____ / _____
Time from order to exam for inpatient stat CT exams	_____ / _____
Time from order to exam for inpatient routine CT exams	_____ / _____
Does the facility perform digital radiography?	O No O Yes
If yes, number of digital radiography images	_____
If yes, number of digital radiography images that had to be repeated and resulted in additional exposure to the patient	_____

Report turnaround time (time from when exam was completed until final report was signed)

	Number of exams completed this month	Number of exams with report signed < 12 hours later	Number of exams with report signed ≥ 12 hours and < 24 hours later	Number of exams with report signed ≥ 24 hours and < 48 hours later	Mean report turnaround time in hours
Radiography	_____	_____	_____	_____	_____
Ultrasound (excluding breast ultrasound)	_____	_____	_____	_____	_____
MRI	_____	_____	_____	_____	_____
CT	_____	_____	_____	_____	_____
PET	_____	_____	_____	_____	_____

4. Outcomes	Number
Liver biopsies performed by radiologists	_____
Liver biopsies performed by radiologists reported as non-diagnostic	_____
Lung biopsies performed by radiologists	_____
Lung biopsies performed by radiologists reported as non-diagnostic	_____
Lung biopsies performed by radiologists resulting in pneumothorax requiring chest tube	_____
Stereotactic breast biopsies performed	_____
Stereotactic breast biopsies performed which were non-concordant with imaging findings	_____

5. Name of person who completed this paper form	
Last name	_____
First name	_____

Monthly Data Form by Physician

Version 1.4

Please note: Fields within bold borders are required for both "green" and "gold" participants. Fields outside bold borders should be entered by "gold" participants only.

1. Facility number	(auto filled)

2. Physician	_____
3. Month / year to which form applies	____/_____ (mm/yyyy)

4. Process measures

Number of digital radiography images	_____
Number of digital radiography images that had to be repeated and resulted in additional exposure to the patient	_____

Report turnaround time (time from when exam was completed until final report was signed)	Number of exams completed this month	Number of exams with report signed < 12 hours later	Number of exams with report signed ≥ 12 hours and < 24 hours later	Number of exams with report signed ≥ 24 hours and < 48 hours later	Mean report turnaround time in hours
Radiography	_____	_____	_____	_____	_____
Ultrasound (excluding breast ultrasound)	_____	_____	_____	_____	_____
MRI	_____	_____	_____	_____	_____
CT	_____	_____	_____	_____	_____
PET	_____	_____	_____	_____	_____

5. Outcomes	**Number**
Liver biopsies performed by radiologist	_____
Liver biopsies performed by radiologist reported as non-diagnostic	_____
Lung biopsies performed by radiologist	_____
Lung biopsies performed by radiologist reported as non-diagnostic	_____
Lung biopsies performed by radiologist resulting in pneumothorax requiring chest tube	_____
Stereotactic breast biopsies performed	_____
Stereotactic breast biopsies performed which were non-concordant with imaging findings	_____

6. Name of person who completed this paper form	
Last name	_____
First name	_____