

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	_____	<input type="checkbox"/> 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	_____	<input type="checkbox"/> Not applicable
Stereotactic breast biopsy	_____	<input type="checkbox"/> Not applicable
Breast ultrasound	_____	<input type="checkbox"/> Not applicable
Ultrasound (excluding breast ultrasound)	_____	<input type="checkbox"/> Not applicable
MRI without contrast	_____	<input type="checkbox"/> Not applicable
MRI with contrast	_____	
MRI with and without contrast	_____	
CT without contrast	_____	<input type="checkbox"/> Not applicable
CT with contrast	_____	
CT with and without contrast	_____	
Nuclear medicine	_____	<input type="checkbox"/> Not applicable
PET	_____	<input type="checkbox"/> Not applicable
PET / CT	_____	<input type="checkbox"/> Not applicable
Radiography	_____	<input type="checkbox"/> Not applicable
Interventional (including IR Fluoroscopy)	_____	<input type="checkbox"/> Not applicable
Fluoroscopy (excluding IR)	_____	<input type="checkbox"/> Not applicable
Bone densitometry	_____	<input type="checkbox"/> 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?	<input type="radio"/> No <input type="radio"/> Yes
MR certification required for technologists?	<input type="radio"/> No <input type="radio"/> Yes
ACLS certification or equivalent required for physicians performing interventional procedures?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> No <input type="radio"/> Yes
Radiologist consult required before ordering image	<input type="radio"/> No <input type="radio"/> Yes, indicate all that apply: <ul style="list-style-type: none"> <input type="checkbox"/> IR <input type="checkbox"/> Neuro IR <input type="checkbox"/> MR with contrast <input type="checkbox"/> CT with contrast <input type="checkbox"/> Stat <input type="checkbox"/> Other
Decision support (appropriateness criteria, etc.) available on order-entry system	<input type="radio"/> No <input type="radio"/> Yes
Patient satisfaction survey specific to radiology in regular use	<input type="radio"/> No <input type="radio"/> Yes, indicate all that apply: <ul style="list-style-type: none"> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient

9. Protocols		Indicate whether a written protocol exists for the event or condition.		
Management of risk of nephrotoxicity	<input type="radio"/> No <input type="radio"/> Yes			
Pregnancy screening	<input type="radio"/> No <input type="radio"/> Yes			
Allergy screening	<input type="radio"/> No <input type="radio"/> Yes			
¹ Communication of critical results	<input type="radio"/> No <input type="radio"/> Yes			
¹ Communication of critical tests	<input type="radio"/> No <input type="radio"/> Yes			
Infection control	<input type="radio"/> No <input type="radio"/> Yes			
MR safety screening	<input type="radio"/> No <input type="radio"/> 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