
The Atlantic Provinces Medical Peer Review



<p>PEER ASSESSMENT REPORT DIAGNOSTIC RADIOLOGY</p>

**Please write legibly and forward to the Peer Review office as quickly as possible.
(PLEASE USE BLACK INK)**

APMPR#: _____

Type of Practice: _____

Group: _____ **Solo:** _____

Date of Assessment: _____

Assessor Name: _____

Assessor Signature: _____

APMPR NUCLEAR MEDICINE – FILM REVIEW SHEET

For each criteria item place a: "√" for Yes, "x" for No and "N/A" for Not Applicable

	Patient 1	Patient 2	Patient 3	Patient 4
Patient identifier (exam #, patient initials)				
Examination date				
Examination type				
Examination clinically indicated				
Final report include:				
- Previous studies available (if applicable)				
- Assessment of the problem requested and documentation in the body of the report				
- Diagnosis not description				
- Recommendations if needed				
Interpreting physician/technologist initials				
Image quality – diagnostic / under diagnostic				

Comments:

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5

APMPR BONE MINERAL DENSITOMETRY – FILM REVIEW SHEET

For each criteria item place a: "√" for Yes, "x" for No and "N/A" for Not Applicable

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Patient identifier (exam #, patient initials)					
Examination date					
Examination clinically indicated					
Final report includes: deformities if present					
Absolute bone density values					
"T" score					
Relative fracture risk					
Significance of change from previous & baseline					
Recommendations for further assessment (if applicable)					
Is the report accurate and does it meet IHF standard for form and content					
Is the report turnaround acceptable					

Comments:

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5

APMPR Radiography – STUDY REVIEW SHEET

For each criteria item place a: "√" for Yes, "x" for No and "N/A" for Not Applicable

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Patient identifier (exam 3, patient initials)					
Examination date					
Examination type					
Examination clinically indicated					
Pertinent clinical issues raised in the request for the examination					
Comparative information with previous examination					
Is the report accurate and does it meet IHF standard for form and content?					
Is the report turnaround acceptable?					
Appropriate imaging sequences?					

Comments:

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5

APMPR GENERAL ULTRASOUND – FILM REVIEW SHEET

For each criteria item place a: "√" for Yes, "x" for No and "N/A" for Not Applicable

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Patient identifier (exam #, patient initials)					
Examination date					
Examination type					
Examination clinically indicated					
Pertinent clinical issues raised in the request for the examination					
Comparative information with previous examination					
Is the report accurate and does it meet IHF standard for form and content?					
Is the report turnaround acceptable?					

Comments:

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5

APMPR COMPUTED TOMOGRAPHY – FILM REVIEW SHEET

For each criteria item place a: “√” for Yes, “x” for No and “N/A” for Not Applicable

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Patient identifier (patient initials)					
Examination date					
Examination type					
Examination clinically indicated					
Pertinent clinical issues raised in the request for the examination					
Comparative information with the previous examination					
Is the report accurate and does it meet IHF standard for form and content?					
Is the report turnaround acceptable?					
Appropriate imaging sequences					

Comments:

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5

