

Please complete this form and email to: [pdp@acrrm.org.au](mailto:pdp@acrrm.org.au), or fax 07 3105 8299

**ACRRM Member Details:**

|  |  |
| --- | --- |
| Member Name: | |
| ACRRM Number: | Provider Number: |

**Review Details:**

|  |  |
| --- | --- |
| Place of Review (e.g. hospital, GP Surgery, Clinic): | |
| Supervising Radiologist: |  |
| Supervisors Signature: |  |

**Film Details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Film for Review** | **Date of Review** | **Type of Film e.g. chest, spine** | **Radiographic findings – The report**   1. **History** 2. **Relevant clinical information** 3. **Impressions** 4. **Conclusion/diagnosis/findings** | **Radiologists comments** |
| **Film 1** |  |  |  |  |
| **Film 2** |  |  |  |  |
| **Film 3** |  |  |  |  |
| **Film 4** |  |  |  |  |
| **Film for Review** | **Date of Review** | **Type of Film e.g. chest, spine** | **Radiographic findings – The report**   1. **History** 2. **Relevant clinical information** 3. **Impressions** 4. **Conclusion/diagnosis/findings** | **Radiologists comments** |
| **Film 5** |  |  |  |  |
| **Film 6** |  |  |  |  |
| **Film 7** |  |  |  |  |
| **Film 8** |  |  |  |  |
| **Film 9** |  |  |  |  |
| **Film 10** |  |  |  |  |
| **Film 11** |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Film for Review** | **Date of Review** | **Type of Film e.g. chest, spine** | **Radiographic findings – The report**   1. **History** 2. **Relevant clinical information** 3. **Impressions** 4. **Conclusion/diagnosis/findings** | **Radiologists comments** |
| **Film 12** |  |  |  |  |
| **Film 13** |  |  |  |  |
| **Film 14** |  |  |  |  |
| **Film 15** |  |  |  |  |

**Results:**

(To be filled in by the doctor after completion of the ‘Film Reviews’ with a radiologists)

|  |
| --- |
| Please list any changes you plan to make in your practice of radiology (reading, interpreting and reporting) on x-rays after completing your film review activity: |