

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

**ACRRM Member Details:**

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

**Review Details:**

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

**Film Details:**

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| --- | --- | --- | --- | --- |
| **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** |       |       |       |       |

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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)

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| 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:      |