The standards of the American College of Radiology (ACR) are not rules but attempt to define principles of practice which should generally produce high-quality radiological care. The physician and medical physicist may exceed an existing standard as determined by the individual patient and available resources. The standards should not be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific procedure or course of conduct must be made by the physician and medical physicist in light of all circumstances presented by the individual situation. Adherence to ACR standards will not assure a successful outcome in every situation. It is prudent to document the rationale for any deviation from these suggested standards in the physician's and medical physicist's policies and procedures manual or, if not addressed there, in the patient's medical record.

1991 (Res. 5)
Revised 1995 (Res. 10)
Revised 1999 (Res. 27)
Effective 1/1/00

ACR STANDARD FOR COMMUNICATION: DIAGNOSTIC RADIOLOGY

I. INTRODUCTION

Communication is a critical component of the art and science of medicine and is especially important in diagnostic radiology. An official interpretation[1] shall be generated following any examination, procedure, or officially requested consultation. In addition, the interpreting physician and the referring physician or other healthcare provider have other opportunities to communicate directly with each other during the course of a patient's case management. Such communication should be encouraged because it promotes optimal patient care and focuses attention on selection of appropriate and cost-effective imaging studies, clinical efficacy, and radiation exposure.

If a radiologic consultation or interpretation occurs regarding a study or patient for which the interpreting physician was not primarily responsible (e.g., second opinion, "outside study"), and that second interpretation or consultation may impact patient care, communication and documentation of that consultation is encouraged.

To promote optimal patient care and enhance the cost-effectiveness of each diagnostic examination, radiologic consultations should be provided and radiologic studies interpreted with appropriate clinical information. The American College of Radiology supports all efforts to obtain relevant clinical data with each consultation request.

II. THE DIAGNOSTIC RADIOLOGY REPORT

An official interpretation (final written report) shall be provided with all radiologic studies regardless of the site of performance (hospital, imaging center, physician office, mobile, etc.). The report should include the following items as a minimum:

[1]The ACR Medical Legal Committee defines official interpretation as that written report (and any supplements or amendments thereto) that attach to the patient's permanent record. In healthcare facilities with a privilege delineation system, such a written report is prepared only by a qualified physician who has been granted specific delineated clinical privileges for that purpose by the facility's governing body upon the recommendation of the medical staff.

A. Demographics

1. Name of patient and another identifier, such as social security number or hospital or office identification number.
2. Name of any referring physician(s) or other healthcare provider.
3. Name or type of examination.
4. Date of the examination.
5. Time of the examination, if relevant (e.g., in patients who are likely to have more than one of a given examination per day).
6. Inclusion of the following additional items is encouraged:
   a. Date of dictation
   b. Date of transcription
   c. Birth date or age
   d. Gender

B. Relevant Clinical Information or ICD-9 Code as Available

C. Body of the Report

1. Procedures and materials
   The report should include a description of the studies and/or procedures performed and any contrast media (including concentration and volume when applicable), medications, catheters, or devices used, if not recorded elsewhere. Any known significant patient reaction or complication should be recorded.
2. Findings
   The report should use precise anatomic and radiologic terminology to describe the findings accurately.
3. Potential limitations
   The report should, when appropriate, identify factors that may limit the sensitivity and specificity of the examination.
4. Clinical issues
   The report should address or answer any pertinent clinical issues raised in the request for the imaging examination.
5. Comparative data
   Comparison with previous examinations and reports should be part of the radiologic consultation and report when appropriate and available.

D. Impression (Conclusion or Diagnosis)

1. Unless the report is brief, each report should contain an "impression" section.
2. A precise diagnosis should be given whenever possible.
3. A differential diagnosis should be given when appropriate.
4. When appropriate, recommend follow-up or additional diagnostic studies to clarify or confirm the impression.

III. OFFICIAL INTERPRETATION (FINAL WRITTEN REPORT)

A. The timeliness of reporting any radiologic examination varies with the nature and urgency of the clinical problem. The final report should be made available in a clinically appropriate, timely manner.

B. The final report should be proofread to minimize typographical errors, deleted words, and confusing or conflicting statements.

C. The final report should be completed in accordance with appropriate state and federal requirements (See the Final Regulations, Mammography Quality Standards Act for Mammography Reporting). Electronic or rubber-stamp signature devices, instead of a written signature, are acceptable if access to them is secure.

D. The final report should be sent to the referring physician or the physician or healthcare provider providing the clinical follow-up. Each facility should develop a policy to ensure proper distribution of the final report.

E. When feasible, a copy of the final report should accompany the transmittal of relevant images to other healthcare professionals.

F. Under some circumstances, practice constraints may dictate the necessity of a preliminary report prior to the preparation of the final report.

G. A copy of the final report should be kept as part of the patient's medical record (paper or electronic) and be retrievable for future reference. Retention of these records should be in accordance with state and federal regulations and facility policies.

IV. DIRECT COMMUNICATION

A. Direct communication can be accomplished in person or by telephone to the referring physician or an appropriate representative.

B. In those situations in which the interpreting physician feels that immediate patient treatment is indicated (e.g., tension pneumothorax), the interpreting physician should communicate directly with the referring physician, other healthcare provider, or an appropriate representative. If that individual cannot be reached, the interpreting physician should directly communicate the need for emergent care to the patient or responsible guardian, if possible.

C. In those situations in which the interpreting physician feels that less urgent findings (compared to B above) or significant unexpected findings are present, the interpreting physician or designee should directly communicate the findings to the referring physician, other healthcare provider, or an appropriate representative.

D. Documentation of direct communication is recommended.

E. Any significant discrepancy between an emergency or preliminary report and the final written report should be promptly reconciled by direct communication with the referring physician, other healthcare provider, or an appropriate representative.

This standard was revised according to the process described elsewhere in this publication by the Standards and Accreditation Committee of the Commission on General and Pediatric Radiology.

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