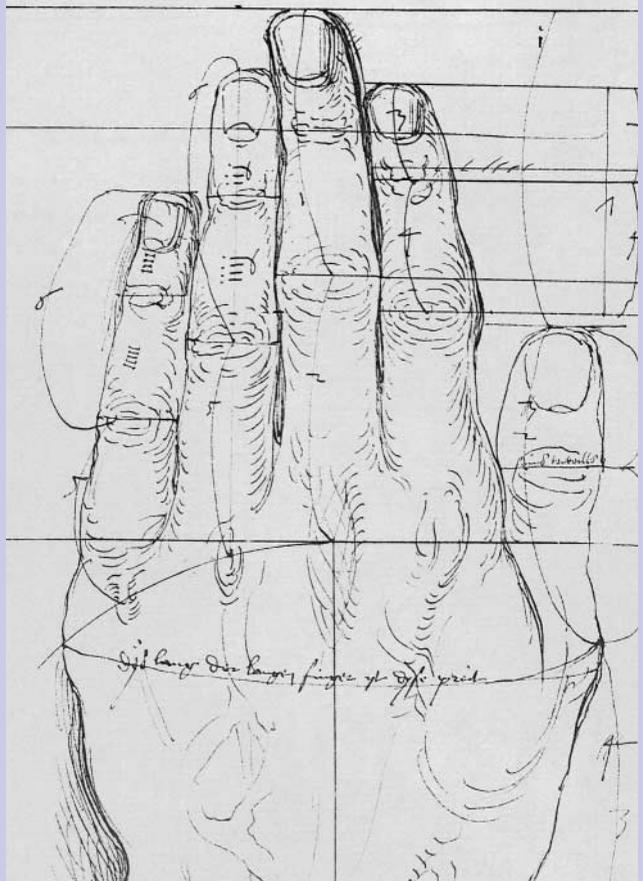


AIUM Standard for Documentation of an Ultrasound Examination



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AMERICAN INSTITUTE OF
ULTRASOUND IN MEDICINE

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The American Institute of Ultrasound in Medicine (AIUM) is an educational, scientific, and professional society concerned with the advancement of the art and science of ultrasound in medicine and research. To promote this mission, the AIUM is pleased to publish the Standard for Documentation of an Ultrasound Examination. We are indebted to the many volunteers who contributed their time, knowledge, and energy to bringing this document to completion, particularly to the members of the AIUM's Clinical Standards Committee.

The AIUM represents the entire range of clinical and basic science interests in medical diagnostic ultrasound and, with hundreds of volunteers, the AIUM has promoted the safe and effective use of ultrasound in clinical medicine for more than 50 years. This document, and others like it, will continue to advance this mission.

AIUM standards are intended to provide the medical ultrasound community with guidelines for the performance and recording of high quality ultrasound examinations. The standards reflect what the AIUM considers the minimum criteria, but are not intended to establish a legal standard of care. AIUM-accredited practices are expected to generally follow the standards with the recognition that deviations from the standards will be needed in some cases depending on patient needs and available equipment. Practices are encouraged to go beyond the standards to provide additional service and information as needed by their referring physicians and patients.



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I. Introduction

Adequate documentation by all members of the diagnostic ultrasound health care team is essential for high-quality patient care. There should be a permanent record of the ultrasound examination and its interpretation. Images of all relevant areas, both normal and abnormal, should be recorded in a retrievable format. Retention of the ultrasound images and report should be consistent both with clinical need and with relevant legal and local health care facility requirements. The reader is urged to refer also to the individual standards for each ultrasound examination since they may contain additional documentation requirements.

II. Documentation Included for the Ultrasound Examination

Official documentation for the ultrasound images or, for example, documentation on a worksheet, should include, but is not limited to, the following:

- Patient's name and other identifying information such as medical record number, identification number, Social Security number, or birth date.*
- Name of patient's health care provider.
- Specific type of ultrasound examination.
- Date of ultrasound examination.*
- Image orientation (as needed).*
- Relevant clinical information and/or ICD 9 code should be noted.
- Identification of the sonographer or sonologist performing the examination is recommended.

*These items must be included on the recorded images.

III. Preliminary Report

Where applicable, the sonographer or sonologist may provide an oral or written summary of preliminary findings.

IV. Final Report Provided by the Interpreting Physician

A final report of the ultrasound findings is included in the patient's medical record. The official final report should include, but is not limited to, the following:

- Patient's name and other identifying information such as medical record number, identification number, Social Security number, or birth date.
- Name of patient's health care provider.
- Specific type of ultrasound examination.
- Date of ultrasound examination.
- Relevant clinical information and/or ICD 9 code should be noted.
- Appropriate anatomic and sonographic terminology should be used; variations from normal size should be accompanied by measurements when appropriate; and limitations of the examination should be noted.
- Comparison with prior relevant imaging studies; recommendations, including appropriate follow-up studies; an impression or conclusion; and a specific diagnosis or differential diagnosis may all be included when appropriate.
- The final report should be generated, signed, and dated by the interpreting physician. (Electronic signature, transmission, and storage of the report is acceptable if patient privacy is assured.)
- Reports should be completed and transmitted to the patient's health care provider in a timely fashion.
- In certain instances, the results of the ultrasound study may need to be directly conveyed to the patient's referring health care provider prior to the final report; documentation of this communication is recommended.

