

AIUM Practice Parameter for

Documentation of an Ultrasound Examination



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AMERICAN INSTITUTE OF ULTRASOUND IN MEDICINE

The American Institute of Ultrasound in Medicine (AIUM) is a multidisciplinary association dedicated to advancing the safe and effective use of ultrasound in medicine through professional and public education, research, development of parameters, and accreditation. To promote this mission, the AIUM is pleased to publish this updated *AIUM Practice Parameter 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.

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.

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



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I. Introduction

Adequate documentation and communication by all members of the diagnostic ultrasound health care team are essential for high-quality patient care. There should be a permanent record of the ultrasound examination and its interpretation. Images of all relevant areas defined in the particular parameter, both normal and abnormal, should be recorded in a retrievable format. Retention of the ultrasound images and report should be consistent both with clinical needs and with relevant legal and local health care facility requirements. Communication between the interpreting physician and referring provider should be clear, timely, and in a manner that minimizes potential errors. All communication should be performed in a manner that respects patient confidentiality. The reader is urged to refer also to the individual parameter for each ultrasound examination, since it may contain additional documentation requirements.

II. Documentation Included for the Ultrasound Examination

Official documentation for the ultrasound images should include but is not limited to the following:

- Patient's name and other identifying information.
- Facility's identifying information.
- Date of ultrasound examination.
- Image orientation when appropriate.

If a worksheet is used and retained, documentation should include:

- Patient's name and other identifying information.
- Date of ultrasound examination.
- Relevant clinical information and/or current version of the appropriate *International Classification of Diseases (ICD)* code.
- Specific ultrasound examination requested.
- Name of patient's health care provider and contact information as appropriate.

III. Final Report Provided by the Interpreting Physician

A signed final report of the ultrasound findings is included in the patient's medical record and is the definitive documentation of the study.

The final report should include but is not limited to the following:

- Patient's name and other identifying information.
- Name of patient's health care provider.
- Location of ultrasound facility and contact information.
- Relevant clinical information, including indication for the examination and/or current version of the appropriate *ICD* code.
- Date of ultrasound examination.
- Specific ultrasound examination performed.
- If endocavitary techniques are used, the method should be specified.

- The report should include comments on the components of the examination as outlined in the relevant practice parameter(s).
- Appropriate anatomic and sonographic terminology should be used. The use of acronyms and abbreviations should be avoided. Variations from normal size should be accompanied by measurements when appropriate (eg, organomegaly and masses).
- Pertinent, commonly used anatomic measurements should be listed (eg, fetal biometry).
- Limitations that compromise the quality of the examination should be noted (eg, high body mass index).
- Comparison with prior relevant imaging studies if available.
- A specific diagnosis or differential diagnosis should be included. An impression or conclusion should be included. A recommendation for follow-up studies should be provided if clinically applicable.
- The final report should be generated, signed, and dated by the interpreting physician in accordance with state and federal requirements. Final reports should be available within 24 hours of completion of the examination or, for nonemergency cases, by the next business day.
- Final reports should be transmitted to the patient's health care provider in a timely fashion and in accordance with state and federal requirements.

IV. Reporting of Nonroutine Results

In certain circumstances, such as immediate patient management or a particular practice environment, a preliminary report of the ultrasound results may be conveyed directly to the patient's referring health care provider before the final report. The preliminary report must contain the patient's identifying information, provider's information, ultrasound facility, contact information, pertinent clinical information, date and time of the ultrasound examination, and specific ultrasound examination performed. The preliminary report contains limited information and may not contain all of the results that will subsequently be found in the final report. Preliminary reports should be labeled as such and should be archived, since clinical decisions may have been made based on a preliminary report. If a preliminary report has been issued, it should be documented in the final report. Any significant discrepancy between the preliminary report and final report should be communicated to the patient's provider and highlighted in the final report, including the date, time, and method of communication.

If results of the ultrasound examination are considered by the interpreting physician to be important and unexpected, or require urgent intervention to ensure appropriate patient care, communication should occur directly between the interpreting physician and the patient's health care provider. Communication by phone or in person is preferred to allow verification of receipt and discussion and should occur in a timely manner in accordance with the patient's clinical state and the ultrasound findings, typically immediately after the examination. The institution's protocol should be followed to minimize potential communication errors. The final report should include all of the elements noted in section III, as well as the date, time, and method that the report was conveyed to the patient's health care provider.

V. Reporting of Ultrasound-Guided Procedures

Documentation of the informed consent communication between the provider and the patient concerning the procedure (including risks, benefits, and alternatives) should be part of the medical record and performed in compliance with local standards and applicable state and federal law. The Joint Commission (TJC) Universal Protocol for the Prevention of Wrong Site, Wrong Procedure, and Wrong Person Surgery must be followed. (http://www.joint-commission.org/standards_information/up.aspx)

A signed final report of the ultrasound-guided procedure is included in the patient's medical record and is the definitive documentation of the procedure. The final report should be generated, signed, and dated by the performing provider/interpreting physician in accordance with state and federal requirements. Final reports should be available within 24 hours of completion of the examination or, for nonemergency cases, by the next business day.

The final report must contain the following:

- Patient's name and other identifying information.
- Facility's identifying information.
- Performing provider/interpreting physician identifying information.
- Pertinent clinical information, including indication for ultrasound guidance.
- Documentation of informed consent.
- Documentation of compliance with the TJC Universal Protocol.
- Date and time of the ultrasound guidance of the procedure.
- Specific ultrasound-guided examination performed, including site and side of body.
- Documentation of changes in the requested procedure should be noted if appropriate.
- Description of the target and relevant associated structures, both normal and abnormal, if clinically applicable.
- Description of the use of ultrasound to localize the target and the essential elements of the procedure, including transducer position, approach to the target, and method of needle tracking (in plane or out of plane). Deviations from standard techniques are described and justified.
- Needle/device type and gauge.
- Number of passes performed.
- Name of medication(s) injected and amount used (if applicable).
- Specimen type and amount removed if any, as well as its disposition.
- Complications.
- Recommendations for follow-up imaging.

Official documentation of ultrasound images appropriate to the procedure being performed should be stored in the patient's medical record. The ultrasound images should include but are not limited to the following:

- Patient's identifying information.
- Facility's identifying information.
- Procedure date.
- Procedure site.

Refer to the relevant parameter for the specific ultrasound-guided procedure as they may contain additional documentation requirements.

Acknowledgments

This parameter was created and revised by the American Institute of Ultrasound in Medicine (AIUM).

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Renamed 2015