Best Practices in Clinical Record Keeping: Documenting Diagnostic Imaging

Introduction

Complete and thorough documentation of diagnostic imaging studies is an important part of the clinical record. The clinical history and examination findings should document the indications for the imaging that is conducted.

Identification

Reports of studiesshould always incorporate complete identifiers including:

- Member name, age/date of birth, sex
- Facility name, address, phone number
- Ordering provider name
- Date of study
- Area of study and views obtained

Report

In-house studies and interpretation of outside films should be an accurate description of all significant diagnostic imaging findings. An “impression” contains a summary of important findings and should contribute to the diagnosis and guide the treatment plan. Recommendations for further imaging studies, other tests or specialty referral should be noted.

Outside Studies

Studies that are conducted and interpreted at another facility should be documented by reports from that facility. These reports should be reviewed, initialed and dated upon receipt. If outside studies are not documented, interpretation should be obtained from a qualified clinician.