

Location (Please circle)

AU NM VAU

X-RAY ASSOCIATES

Quality Assurance Form

FAX: (289) 553-5042

STAFF MEMBER: _____

PATIENT NAME: _____

DATE: _____

PATIENT ID: _____

TIME: _____

ACCESSION NUMBER: _____

RIS / PACS ISSUES

☐ UNSPECIFIED IMAGES

☐ IMAGES UNDER WRONG PATIENT

☐ MERGE PATIENT RECORDS

WORKSTATION

☐ SCANNER IS NOT WORKING

☐ APPLICATION IS NOT WORKING

☐ COMPUTER IS NOT BOOTING UP

TRANSCRIPTION

☐ PUT BACK FOR DICTATION

☐ FIX BATCH ISSUE

☐ PRINT BATCH ISSUE

REPORT ERRORS / SERVICE ISSUES

☐ CORRECTION REQUIRED

☐ WRONG REFERRING PHYSICIAN

☐ INCORRECT MAIL/FAX INFORMATION

☐ ADDENDUM REQUIRED

☐ PATIENT COMPLAINTS

☐ PHYSICIAN COMPLAINT

☐ ADDENDUM COMPLETED

☐ REPORT ENCLOSED

☐ _____

BILLING

Rev. date: Feb. 12 2025