



RADIOLOGY

The Chest X ray SOP states that lateral view should only be done if antero-posterior view is NORMAL. X-rays should ideally be reviewed by 2 clinicians who are trained and / or experienced in x-ray interpretation. The original x-rays should also be stored for future review e.g. by scanning or digital copy obtained.

**CHEST X RAY 1:
ALL SITES**

<input type="checkbox"/> Admission <input type="checkbox"/> Deterioration <input type="checkbox"/> Readmission <input type="checkbox"/> Other					
___/___/_____ D D / M M / Y Y Y Y	Rotated? Y N	Too Dark Y N	Too light Y N	Repeated? Y N	Lateral view? Y N
Result after review by 2 clinicians	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormality on left	<input type="checkbox"/> Abnormality on right	<input type="checkbox"/> Bilateral abnormality	<input type="checkbox"/> Abnormality seen on lateral view ONLY
Abnormality, select all that apply	<input type="checkbox"/> Air space opacification/consolidation	<input type="checkbox"/> Air bronchogram	<input type="checkbox"/> Infiltrates	<input type="checkbox"/> Lobar collapse	<input type="checkbox"/> Tracheal displacement
	<input type="checkbox"/> Airway compression	<input type="checkbox"/> Soft tissue density suggesting lymphadenopathy	<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Nodular picture / Miliary	<input type="checkbox"/> Signs of failure or fluid overload
Other abnormality	<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Rib fracture	<input type="checkbox"/> Mediastinal mass	<input type="checkbox"/> Pneumothorax	<input type="checkbox"/> Rib features consistent with rickets
	Other				

**CHEST X RAY 2:
ALL SITES**

<input type="checkbox"/> Admission <input type="checkbox"/> Deterioration <input type="checkbox"/> Readmission <input type="checkbox"/>					
___/___/_____ D D / M M / Y Y Y Y	Rotated? Y N	Too Dark Y N	Too light Y N	Repeated? Y N	Lateral view? Y N
Result after review by 2 clinicians	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormality on left	<input type="checkbox"/> Abnormality on right	<input type="checkbox"/> Bilateral abnormality	<input type="checkbox"/> Abnormality seen on lateral view ONLY
Abnormality, select all that apply	<input type="checkbox"/> Air space opacification/consolidation	<input type="checkbox"/> Air bronchogram	<input type="checkbox"/> Infiltrates	<input type="checkbox"/> Lobar collapse	<input type="checkbox"/> Tracheal displacement
	<input type="checkbox"/> Airway compression	<input type="checkbox"/> Soft tissue density suggesting lymphadenopathy	<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Nodular picture / Miliary	<input type="checkbox"/> Signs of failure or fluid overload
Other abnormality	<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Rib fracture	<input type="checkbox"/> Mediastinal mass	<input type="checkbox"/> Pneumothorax	<input type="checkbox"/> Rib features consistent with rickets



CHAIN Number [1][0][0][0][1][][][][]



	Other
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**CHEST X RAY 3:
ALL SITES**

<input type="checkbox"/> Admission <input type="checkbox"/> Deterioration <input type="checkbox"/> Readmission <input type="checkbox"/>					
___/___/_____ D D / M M / Y Y Y Y	Rotated? Y N	Too Dark Y N	Too light Y N	Repeated? Y N	Lateral view? Y N
Result after review by 2 clinicians	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormality on left	<input type="checkbox"/> Abnormality on right	<input type="checkbox"/> Bilateral abnormality	<input type="checkbox"/> Abnormality seen on lateral view ONLY
Abnormality, select all that apply	<input type="checkbox"/> Air space opacification/consolidation	<input type="checkbox"/> Air bronchogram	<input type="checkbox"/> Infiltrates	<input type="checkbox"/> Lobar collapse	<input type="checkbox"/> Tracheal displacement
	<input type="checkbox"/> Airway compression	<input type="checkbox"/> Soft tissue density suggesting lymphadenopathy	<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Nodular picture / Miliary	<input type="checkbox"/> Signs of failure or fluid overload
Other abnormality	<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Rib fracture	<input type="checkbox"/> Mediastinal mass	<input type="checkbox"/> Pneumothorax	<input type="checkbox"/> Rib features consistent with rickets
	Other				

ABDOMINAL X RAY:

<input type="checkbox"/> Admission <input type="checkbox"/> Deterioration <input type="checkbox"/> Readmission		
Date ___/___/_____ D D / M M / Y Y Y Y	Indication:	<input type="checkbox"/> ? Obstruction <input type="checkbox"/> ? Perforation <input type="checkbox"/> Other
Result <input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Perforation confirmed	<input type="checkbox"/> Other	
<input type="checkbox"/> Obstruction confirmed		
<input type="checkbox"/> Gaseous distension		
<input type="checkbox"/> Megacolon		

Wrist X-ray

Date ___/___/_____ D D / M M / Y Y Y Y	Indication:	<input type="checkbox"/> Suspected rickets <input type="checkbox"/> Other
Result <input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
	<input type="checkbox"/> Fraying of distal radius and ulna	<input type="checkbox"/> Fracture



CHAIN Number [1][0] [0][0][1] [][][]



Other Radiology		
Date ___/___/_____ <i>D D / M M / Y Y Y Y</i>	Test done	
Result <input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal – summarise below	

