Circle Field Center Location:
BU CU DK UP

Ultrasound Research Lab

LLFS Action Form for Carotid Ultrasound Alerts

Is this an alert? ❑ Yes ❑ Findings questionable, technologist requests MD review ❑ No

Participant's Name: _____ **Date of Scan:** __ __ / __ __ / 20 __ __

Participant Name Code_____**Study ID:** _____ **Visit #:** _____

Age _____ ❑ Male ❑ Female

Date Scan Received: __ __ / __ __ / 20 __ __ **Date Scan Reviewed by URL:** __ __ / __ __ / 20 __ __

Technologist's Findings and/or Questions:

Technologist's ID and signature: _____ (***If not an alert Stop Here***)

Form Delivered to URL Physician: _____ By: _____

Documentation Attached: ❑ CIMT WS

Date Delivered: __ __ / __ __ / 20 __ __

_____

URL Physician Findings:

Does the URL Physician consider findings to be potentially clinically significant? ❑ Yes* ❑No

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URL Physician signature: _____ **Date:** __ __ / __ __ / 20 __ __

***If yes, URL must notify site within 48 hours of receiving notification.**

Participant Name Code_____ **Study ID:** _____

Date URL Notified by Physician: __ __ / __ __ / 20 __ __

Date Site Notified*: __ __ / __ __ / 20 __ __ **Site Person Notified:**_____

_____

Site Investigator's/Project Coordinator's Action

❑ Participant notified: ❑ Phoned ❑Mailed **Date Notified** __ __ / __ __ / 20 __ __

Pertinent medical history and symptoms reported by participant to site:

Does the site recommend contacting the participant's physician? ** ❑ Yes ❑No
**If yes, complete remainder of form. If no, indicate below date alert resolved.

Participant's physician contacted? ❑Yes…… **Date of contact:** __ __ / __ __ / 20 __ __
❑No…… specify why not:_____

Date results letter sent to participant: __ __ / __ __ / 20__ __

Date results letter sent to physician: __ __ / __ __ / 20 __ __

Alert Resolved on: __ __ / __ __ / 20 __ __