

RADIOLOGY SKILLS CHECKLIST

NAME: _____ **SIGNATURE:** _____ **DATE:** _____

1 - Highly skilled (can function well independently, strong experience)

2 - Proficient (experienced, may need occasional review/assistance) **3 - Limited Skill** (limited to no experience)

GENERAL DIAGNOSTIC

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Abdomen | | | |
| Bilateral Mammogram | | | |
| Needle Localization | | | |
| Extremities | | | |
| Specimen Radiographs | | | |
| Therapy Replacement Film | | | |
| Small Bowel Series | | | |
| Hypotonic Duodenography | | | |
| Foreign Body Localization | | | |
| Hysterosalpingogram | | | |
| Voiding Cystogram | | | |
| T-Tube Cholangiogram | | | |
| Transhepatic Cholangiogram | | | |
| C-Arm Fluoroscope | | | |
| Thoracic Spine | | | |
| Lumbar Spine | | | |
| Skull | | | |
| Chest | | | |
| I.V.P. | | | |
| Bone Survey | | | |
| Bone Age | | | |
| Hip | | | |
| Barium Enema | | | |
| Barium Swallow | | | |
| Gall Bladder | | | |
| Esophagram | | | |
| GI Series | | | |
| ER Exams | | | |
| OR Exams | | | |
| Myelogram | | | |
| Mastoids | | | |
| Tomogram | | | |
| Lung Biopsy | | | |
| ERCP | | | |
| Portable Exams | | | |
| Pediatric Exams | | | |
| Salpingogram | | | |
| Sialography | | | |
| Cervical Spine | | | |
| Bronchogram | | | |

CT

| Skills (check appropriate box) | 1 | 2 | 3 |
|----------------------------------|---|---|---|
| Brain with contrast | | | |
| Brain without contrast | | | |
| Biopsy Procedures | | | |
| Lumbar Spine | | | |
| Cervical Spine | | | |
| TM Joints | | | |
| Pancreas | | | |
| Abdomen | | | |
| Pelvis | | | |
| IAC | | | |
| Orbits | | | |
| Liver | | | |
| Larynx | | | |
| Chest | | | |
| Renal Cyst Puncture | | | |
| Type of Equipment (enter below): | | | |
| • | | | |
| • | | | |
| • | | | |
| • | | | |

CT Licensing

State: _____ State: _____
 License #: _____ License #: _____
 Exp. Date: _____ Exp. Date: _____
 Type of Registration: _____
 Number: _____
 Years of Experience: _____

RADIATION THERAPY

| Skills (check appropriate box) | 1 | 2 | 3 |
|-----------------------------------|---|---|---|
| Linear Accelerator | | | |
| Linear Accelerator with Electrons | | | |
| Simulation of Treatment Site | | | |
| Treatment Planning | | | |
| Hyperthermia TMT | | | |
| Dosimetry | | | |
| Brachy Therapy | | | |
| IMRT | | | |
| 3D Planning | | | |

NUCLEAR MEDICINE

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Cerebral Blood | | | |
| GI Bleeding Study | | | |
| I-131 Therapy | | | |
| Thallium Stress Test | | | |
| SPECT Scanning | | | |
| I-123 Uptake | | | |
| Thyroid Therapy | | | |
| Bone Scan | | | |
| Gallium Scan | | | |
| Lung Scan | | | |
| Muga Scan | | | |
| Renal Scan | | | |
| Thyroid Scan | | | |

SPECIAL PROCEDURES

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Selective Angiography | | | |
| Carotid Angiogram | | | |
| Brachial Arteriogram | | | |
| Arch Arteriogram | | | |
| Renal Arteriogram | | | |
| Femoral Arteriogram | | | |
| Abdominal Arteriogram | | | |
| Mesenteric Arteriogram | | | |
| Peripheral Arteriogram | | | |

Special Procedures Licensing

State: _____ State: _____
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ULTRASOUND – ABDOMINAL

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Pancreas | | | |
| Liver | | | |
| Gall Bladder | | | |
| Biliary Tract | | | |
| Renal | | | |
| Aorta/Great Vessels | | | |
| Spleen | | | |
| UGI & Small Bowel | | | |
| Cyst Aspirations | | | |
| Biopsy Guidance | | | |
| Pelvic | | | |

ULTRASOUND – OB/GYN

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Uterus/Ovaries | | | |
| Transvaginal Probe | | | |
| Fetal Measurements for Age | | | |
| Gestation Sac Measurement | | | |
| Amniocentesis Guidance | | | |

ULTRASOUND – SMALL PARTS

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Thyroid | | | |
| Breast | | | |
| Prostate | | | |
| Transrectal Probe | | | |
| Scrotum | | | |

ULTRASOUND – SPECIALS

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Neonatal Head | | | |
| OPG Eye | | | |
| Trans-esophageal | | | |
| Trans Cranial Doppler | | | |

CATH LAB

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Pulmonary Arteriogram | | | |
| Atherectomy | | | |
| Balloon Pumps | | | |
| External Pacemakers | | | |
| Internal Pacemakers | | | |
| Coronary Angioplasty | | | |

ECHO

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Real Time | | | |
| Doppler | | | |
| M-Mode | | | |
| Color Flow | | | |

VASCULAR

| Skills (check appropriate box) | 1 | 2 | 3 |
|--------------------------------|---|---|---|
| Carotids | | | |
| Upper Extremity Venous | | | |
| Upper Extremity Arterials | | | |
| Lower Extremity Venous | | | |
| Lower Extremity Arterials | | | |
| Venous for DVT | | | |
| Venous for Mapping | | | |
| Arterial Pressures & Imaging | | | |
| Color Flow | | | |
| Popliteal | | | |
| TCD | | | |
| Penile Doppler | | | |
| IPG (arms & legs) | | | |
| PVR (arms & legs) | | | |

MRI

| Skills (check appropriate box) | 1 | 2 | 3 |
|----------------------------------|---|---|---|
| T-1 Weighted Images | | | |
| Surface Coils | | | |
| Partial Saturation Images | | | |
| T-2 Weighted Images | | | |
| Gradient Echo Imaging | | | |
| Multiplanar Reconstruction | | | |
| Spin-Echo Images | | | |
| MR Angiography | | | |
| Type of Equipment (enter below): | | | |
| • | | | |
| • | | | |
| • | | | |
| • | | | |

MRI Licensing

Type of Registration: _____

Number: _____

Years of Experience: _____

Type of Registration: _____

Number: _____

Years of Experience: _____