Stereotactic Breast Biopsy Quality Control Checklist

Department of Diagnostic Radiology
Site: _____

Monthly, Quarterly, and Semi-Annual Tests

(date, initial and enter number where appropriate)

Year												
Month	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Visual Checklist (monthly)												
Repeat Analysis (≤20%) (Semi-annually)												
Fixer (≤0.05 gm/m^2) (quarterly)												
Darkroom Fog (≤ 0.05) (Semi-annually)												
Screen-Film Contact (Semi-annually)												
Compression (25-45 lb) (Semi-annually)												

Date:	**Test:**	**Comments:**

Physician Review _____ Date: _____

Medical Physicist Review _____ Date: _____

Figure 12. Monthly, Quarterly and Semi-Annual checklist for Stereotactic Breast Biopsy QC Tests.