Sample Healthcare Facility

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Final Radiology Report

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Patient Name:	Doe, Jane	**MRN:**	M000000745
DOB (Age):	4/21/YYYY (93)	**Gender:**	Female
Date of Exam:	12/8/YYYY 10:15:25 PM	**Accession:**	642.002SJDD
Referring Physician:	James Smith, MD	**# of Images:**	216

EXAM:
MR Head Without and With Intravenous Contrast

CLINICAL HISTORY:
The patient is a 32 years female; Sudden onset of unresponsiveness and total body weakness with inability to speak

TECHNIQUE:
Magnetic resonance images were obtained of the head/brain without and with intravenous contrast in multiple planes.

CONTRAST:
9 mL of MULTIHANCE was administered intravenously.

COMPARISON:
MR BRAIN 6/6/YYYY 2:49:53 PM

FINDINGS:
Hemorrhage: No intracranial hemorrhage.
Brain: Flair/T2 lesions demonstrate a few scattered white matter hyperintensities measuring up to 4 mm in diameter. There is no associated edema. No abnormal enhancement. No restriction of diffusion to suggest acute infarct. No mass.
Ventricles: Unremarkable. No hydrocephalus. No midline shift.
Bones: Unremarkable.
Sinuses: Unremarkable as visualized. No acute sinusitis.
Other findings: None.

IMPRESSION:
1. Small focal white matter hyperintensities. Consider demyelination, migraine headache change, vasculitis, or early chronic microangiopathic white matter change. This is unchanged from 6/6/YYYY.
2. No enhancing lesions. No acute infarct. No intracranial hemorrhage.
3. There is no interval change from the prior examination.

Dictated and Authenticated by: [RADIOLOGIST NAME]
7/10/YYYY 11:58:08 PM Pacific Time (US & Canada)

Thank you for allowing us to participate in the care of your patient.