**Stop the Line Quality Reporting Form**

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| Date: | Diagnostic Imaging Department: |
| Patient Name: | Who was Present: |
| Medical Record #: | Referring Physician: |
| **To be completed by Staff: Mark all that apply** | |

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| Dissatisfaction | Incorrect Body Part | Behavior, Patient | CNA/MA |
| Medication | Incorrect Exam Ordered | Documentation | RN |
| Security | Incorrect Laterality | IV Issues | Tech |
| Diagnosis Related | Incorrect DOB | Safety incl: Falls, Injury | Clerical |
| Equipment | Incorrect Barcode sticker on Req. | Comments filled out by | Scheduling |
| Supplies | Improper Pt Prep | Referring Doctor | Transport |
|  | Communication/Conduct, Staff | No ID armband on pt | Other |

**Briefly describe the event that caused Stop the Line:**

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**Immediate Action Taken:**

(ie. if incorrect laterality ordered, ordering physician contacted and new order put in) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was the Line Stopped before reaching the patient? Yes or No** (please circle)

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| **Manager / UBT Reviewed: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  **Date Initials** |

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