



American College of Radiology
 MRI Accreditation Program
 1891 Preston White Drive
 Reston VA 20191-4397

Phantom Data Form Label here

MRI Phantom – Site Scanning Data Form

Please complete one copy of these data for each MR Magnet being evaluated. Photocopy this blank form for additional magnets. Detailed instructions for scanning the MRI phantom are attached. All information on this data sheet must be accurately specified. Please print or type. Please place your Phantom Data Form Label in the space above. **Return completed form with phantom images.**

1. MR Manufacturer: check one

- | | | | | |
|--------------------------------------|---|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> ELS Elscint | <input type="checkbox"/> HI Health Images | <input type="checkbox"/> OTS Otsuka | <input type="checkbox"/> RES Resonex | <input type="checkbox"/> TCH Technicare |
| <input type="checkbox"/> FON Fonar | <input type="checkbox"/> HIT Hitachi | <input type="checkbox"/> PIC Picker | <input type="checkbox"/> SIE Siemens | <input type="checkbox"/> TOS Toshiba |
| <input type="checkbox"/> GE GE | <input type="checkbox"/> IN Instrumentarium | <input type="checkbox"/> PHI Philips | <input type="checkbox"/> SHI Shimadzu | <input type="checkbox"/> OTH Other
specify _____ |

2. Model Name: _____ **3. Serial Number:** _____

4. Software Version: _____ **5. Year Manufactured:** _____

6. Magnetic Field Strength: check one

<input type="checkbox"/> ¹ 0.064	<input type="checkbox"/> ² 0.2 T	<input type="checkbox"/> ³ 0.3 T	<input type="checkbox"/> ⁴ 0.35 T
<input type="checkbox"/> ⁵ 0.5 T	<input type="checkbox"/> ⁶ 1.0 T	<input type="checkbox"/> ⁷ 1.5 T	<input type="checkbox"/> ⁹⁹ Other specify

7. Operating Location: check one

<input type="checkbox"/> ⁶ Fixed	<input type="checkbox"/> ² Fixed Trailer	<input type="checkbox"/> ³ Mobile Trailer	<input type="checkbox"/> ⁹ Other specify
---	---	--	---

Pulse Sequence Acquisition Parameters

*In the box below each parameter:
 Record actual values if they differ from the prescribed protocol parameters or
 Place a check mark to indicate use of prescribed parameter.
 Fill in all parameters for "Your Site's Axial T1- and T2-weighted Brain Scan."*

	a	b	c	d	e	f	g	h	i	j	k	l	
	Study	Pulse Sequence	TR (ms)	TE (ms)	FOV (cm)	Number of Slices	Slice Thickness (mm)	Slice Gap (mm)	NEX	Matrix		Routine Receive Band-Width (kHz)	Scan Time (min:sec)
8.	ACR Sagittal locator	Spin Echo	200	20	25	1	20	N/A	1	256	256		0:56
									N/A				
9.	ACR Axial T1	Spin Echo	500	20	25	11	5	5	1	256	256		2:16
10.	ACR Axial T2 Double-echo	Spin Echo	2000	20/80	25	11	5	5	1	256	256		8:56
				/									
11.	Your Site's Axial T1 weighted Brain Scan				Freq:	11	5	5					
					Phase:								
12.	Your Site's Axial T2 weighted Brain Scan				Freq:	11	5	5					
					Phase:								

13. Scan Options Used on the ACR Spin-echo T1- and T2-weighted Axial Scans: _____

14. Scan Options Used on "Your Site's Axial T1- and T2-weighted Brain Scans:" _____

15. Serial number of phantom used for testing _____

Date of Testing: _____ Testing Performed by: _____ Phone: _____
(Please Print)