

# 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 ( $\leq 20\%$ ) (Semi-annually)												
Fixer ( $\leq 0.05 \text{ gm/m}^2$ ) (quarterly)												
Darkroom Fog ( $\leq 0.05$ ) (Semi-annually)												
Screen-film Contact (Semi-annually)												
Compression (25-40 lb) (Semi-annually)												

**Date:**

**Test:**

**Comments:**


Physician Review \_\_\_\_\_ Date: \_\_\_\_\_

Medical Physicist Review \_\_\_\_\_ Date: \_\_\_\_\_

Figure 12. Monthly, quarterly, and semiannual checklist for Stereotactic Breast Biopsy QC Tests.