



## Final Radiology Report

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<b>Patient Name:</b>	Doe, Jane	<b>MRN:</b>	M00000745
<b>DOB (Age):</b>	4/21/YYYY (93)	<b>Gender:</b>	Female
<b>Date of Exam:</b>	12/8/YYYY 10:15:25 PM	<b>Accession:</b>	642.002SJDD
<b>Referring Physician:</b>	James Smith, MD	<b># of Images:</b>	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.

#### CONFIDENTIALITY STATEMENT

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