Facility:

Colorado Mammography Project

Radiology Form
Version 1.8 02/10/02

SSN#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Patient ID:** ______________ **Date of Study:** ___ ___ / ___ ___ / ___ ___

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___ **Name:** ______________________________

Image:

- ❑ Both breasts
- ❑ Left breast only
- ❑ Right breast only

Referring Physician: ______________________________

Address: ______________________________

Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Tech: ______________ **Location:** ______________

Reason for visit: (check one)

- ❑ Asymptomatic (screening)
- ❑ Symptomatic (problem solving)
- ❑ Continued work-up (problem solving)
- ❑ Short-term follow-up
- ❑ Other

Type of exam: (check one)

- ❑ Mammogram
- ❑ Extra Views
- ❑ U/S
- ❑ Ductogram
- ❑ MRI
- ❑ CT

	Guidance:			
❑ FNA:	❑ U/S	❑ Stereo	❑ None	❑ Mammotone
❑ Core Bx:	❑ U/S	❑ Stereo	❑ None	❑ Mammotone
❑ Needle Loc:	❑ U/S	❑ Stereo	❑ None	❑ Mammotone
❑ Cyst Aspiration				
❑ Scinitigraphy				
❑ Digital				
❑ Nuclear Medicine				

1. Significant changes since last film?

- ❑ No ❑ Yes
- ❑ Not applicable
- ❑ Films not comparable
- ❑ No previous films
- ❑ Waiting for outside films

2. Implants? ❑ Right ❑ Left ❑ Both

3. Breast density?

- ❑ Extremely dense (>75%)
- ❑ Heterogen. Dense (50-75%)
- ❑ Scattered fibro. Dense (25-50%)
- ❑ Entirely fat (<25%)

4. ULTRASOUND REPORT (if applicable) **Date:** ___ ___ / ___ ___ / ___ ___

MD Code: ______________

Image: ❑ Right only ❑ Left only ❑ Both breasts

Normal: ❑ Yes ❑ No

	Right	Left
Cyst	❑	❑
Solid Mass	❑	❑
Other	❑	❑

ASSESSMENT AFTER ULTRASOUND:

RIGHT BREAST 0 1 2 3 4 5 **LEFT BREAST** 0 1 2 3 4 5

5. Are you aware of any palpable masses in the patient's breast(s)?

❑ No ❑ Yes IF YES, which breast(s)? ❑ Right ❑ Left ❑ Both

6. Mammo. Findings: (circle)

	RIGHT						LEFT					
ACR Assessment Code	0	1	2	3	4	5	0	1	2	3	4	5

REMARKS:

Date read: ___ ___ / ___ ___ / ___ ___ **MD Code:** ______________________________

Double read: ❑ No ❑ Yes **If yes:** RCode (0-5): ________ LCode (0-5): ________ MD Code: ________

Recommendation for next mammogram:

- ❑ 1 year
- ❑ 2 years
- ❑ Short-term, 6 months
- ❑ at age 40
- ❑ Repeat tech
- ❑ N/A
- ❑ Other: ______________

Recommendation for follow-up action:

❑ Immediate ❑ N/A ❑ Other: ______________

Follow-up recommended procedures:

❑ Clinical Follow Up	❑ Needle Loc	❑ Cyst Aspiration
❑ Additional views	❑ FNA	❑ Surgical Consult
❑ Ultrasound	❑ Core Biopsy	❑ Biopsy – NOS
❑ Ductogram	❑ Open Biopsy	❑ MRI
❑ Other: ______________		