

Patient's Name _____ Mammogram ID _____

Radiologist's Name _____ Interpretation Date _____

Indication for Exam (check one)

- | | |
|---|--|
| <input type="checkbox"/> Screening | <input type="checkbox"/> Short interval follow-up of an abnormal mammogram |
| <input type="checkbox"/> Additional work-up of abnormal mammogram | <input type="checkbox"/> Evaluation of a breast problem |

Type of Exam (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Standard screening views (1-3 views) | <input type="checkbox"/> Diagnostic view (additional magnification, cone, compression views) |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Other |

Mammogram(s) used for comparison?

- | | |
|-----------------------------|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes (Please specify month and year) _____ |
|-----------------------------|--|

Tissue Density (that of denser breast)

- | | |
|---|--|
| <input type="checkbox"/> Almost entirely fat | <input type="checkbox"/> Heterogeneously dense |
| <input type="checkbox"/> Scattered fibroglandular densities | <input type="checkbox"/> Extremely dense |

Assessment (per breast)

	Both	Left	Right
0 - Incomplete: Need additional imaging evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 - Negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 - Benign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 - Probably benign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 - Suspicious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 - Highly suggestive of malignancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Most Significant Finding for Assessments 0,3,4 and 5 (check one)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> A
Architectural
Distortion | <input type="checkbox"/> B
Both (Ca +
Mass, Density
or a.d.) | <input type="checkbox"/> C
Calcification | <input type="checkbox"/> D
Density
(one view only) |
| <input type="checkbox"/> F
Focal
Asymmetric
Densities | <input type="checkbox"/> M
Mass | <input type="checkbox"/> N
Neodensity | <input type="checkbox"/> S
Single Dilated Duct |

Recommendation (check all that apply)

	Both	Left	Right
Normal interval follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional views	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short-term follow-up mammography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine needle aspiration (including cyst aspiration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Core biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consider surgical biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical examination for further diagnostic evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

