

<p>COMMENTS:</p>	<p style="text-align: center;">- Affix label here-</p> <p>Clinical Center/ID: _____ - _____ - _____</p> <p>First Name _____ M.I. _____</p> <p>Last Name _____</p>
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1. Contact date: (M/D/Y)
2. Staff person: _____
3. Contact type:
 - ₁ Phone
 - ₂ Mail
 - ₃ Visit
 - ₈ Other
4. Visit type:
 - ₁ Screening #
 - ₂ Semi-Annual #
 - ₃ Annual #
 - ₄ Non-Routine
5. Date of mammogram: (M/D/Y)
6. Performed by:

MD Name: _____

Clinic Name: _____

Address: _____

City/State/Zip: _____

Phone: _____
7. Date mammogram report reviewed: (M/D/Y)
8. Report reviewed by: _____
9. Summary of mammogram report (*Mark one.*):

	9.1. Right	9.2. Left
Negative	<input type="checkbox"/> ₀	<input type="checkbox"/> ₀
Benign finding - negative	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Probably benign finding - short interval follow-up suggested	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Suspicious abnormality - biopsy should be considered	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
Highly suggestive of malignancy	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
Not done	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉

10. Was a referral made for follow-up care?
 - ₀ No
 - ₁ Yes

- 10.1. Referred by: _____
- 10.2. Date of referral: (M/D/Y)
- 10.3. Referred to:

MD/Clinic: _____

Address: _____

Phone: _____

11. Repeat mammogram recommended:
 - ₁ Immediately/ASAP
 - ₂ Less than one year
 - ₃ One year
 - ₄ Two years
 - ₈ Other (*Specify*): _____

12. Final Follow-Up Results:

	Right	Left
Normal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₀
Benign changes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Possibly malignant	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Cancer	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃

K _____ V _____