COMMENTS

- Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

1. Contact Date: ___-___-___ (M/D/Y)
2. Requested By: ___
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 transvaginal uterine ultrasound:
   ___-___-___ (M/D/Y)
6. Transvaginal uterine ultrasound performed by:
   Name _____
   Address _____
   City/State/Zip _____
   Phone: _____
7. Date report reviewed:
   ___-___-___ (M/D/Y)
8. Report reviewed by:
   ___ _____
9. Summary of report:
   - ☐ 1 Endometrial thickness ≤ 5 mm
   - ☐ 2 Endometrial thickness > 5 mm
   - ☐ 3 Unable to evaluate thickness due to leiomyomata
   - ☐ 4 No uterus seen
   - ☐ 9 Unable to perform successfully or participant refused
10. Pelvic pathology present?
    ☐ 0 No ☐ 1 Yes →

	No	Yes
10.1. Polyps	☐ 0	☐ 1
10.2. Uterine mass	☐ 0	☐ 1
10.3. Pelvic fluid	☐ 0	☐ 1
10.4. Ovarian mass	☐ 0	☐ 1
10.5. Other	☐ 0	☐ 1

10.5.1. Side: ☐ 1 Right ☐ 2 Left ☐ 3 Both

11. Other pathology present outside the reproductive structures?
    - ☐ 0 No
    - ☐ 1 Yes *(Specify)*: _____
12. Was significant endometrial cavity fluid seen?
    - ☐ 0 No
    - ☐ 1 Yes

13. Was a referral made for follow-up care?
    - ☐ 0 No
    - ☐ 1 Yes →

    13.1. Referred by: ___ _____

    13.2. Date of referral: ___-___-___ (M/D/Y)

    13.3. Referred to: _____

    13.4. Endometrial follow-up results
    - ☐ 0 Normal
    - ☐ 1 Hyperplasia
    - ☐ 2 Cancer

    13.5. Pelvic pathology follow-up results
    - ☐ 0 Normal/benign
    - ☐ 1 Cancer

K _____ V _____