COMMENTS:

- Affix label here-
Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __
First Name ______________________M.I.______
Last Name ________________________________

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	☐0	☐0
Benign finding - negative	☐1	☐1
Probably benign finding - short interval follow-up suggested	☐2	☐2
Suspicious abnormality - biopsy should be considered	☐3	☐3
Highly suggestive of malignancy	☐4	☐4
Not done	☐9	☐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	☐0	☐0
Benign changes	☐1	☐1
Possibly malignant	☐2	☐2
Cancer	☐3	☐3

K _______ V _______