Facility:

Colorado Mammography Project

Radiology Form
Version 1.8 02/10/02

SSN#: __ __ - __ __ __ - __ __ __ __ Record 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	☐ FNA
☐ Extra Views	☐ Core Bx:
☐ U/S	☐ Needle Loc:
☐ Ductogram	☐ Cyst Aspiration
☐ MRI	☐ Scinitigraphy
☐ CT	☐ Digital
	☐ Nuclear Medicine

Guidance:

☐ U/S	☐ Stereo	☐ None	☐ Mammotone
☐ U/S	☐ Stereo	☐ None	☐ Mammotone
☐ U/S	☐ Stereo	☐ None	☐ Mammotone

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 _____