Patient's Name_____ Mammogram ID_____

Radiologist's Name_____ Interpretation Date_____

Indication for Exam (check one)

☐	Screening	☐	Short interval follow-up of an abnormal mammogram
☐	Additional work-up of abnormal mammogram	☐	Evaluation of a breast problem

Type of Exam (check all that apply)

☐	Standard screening views (1-3 views)	☐	Diagnostic view (additional magnification, cone, compression views)
☐	Ultrasound	☐	Other

Mammogram(s) used for comparison?

☐	No	☐	Yes (Please specify month and year) _____

Tissue Density (that of denser breast)

☐	Almost entirely fat	☐	Heterogeneously dense
☐	Scattered fibroglandular densities	☐	Extremely dense

Assessment (per breast)	**Both**	**Left**	**Right**
0 - Incomplete: Need additional imaging evaluation	☐	☐	☐
1 - Negative	☐	☐	☐
2 - Benign	☐	☐	☐
3 - Probably benign	☐	☐	☐
4 - Suspicious	☐	☐	☐
5 - Highly suggestive of malignancy	☐	☐	☐

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

☐	**A** Architectural Distortion	☐	**B** Both (Ca + Mass, Density or a.d.)	☐	**C** Calcification	☐	**D** Density (one view only)
☐	**F** Focal Asymmetric Densities	☐	**M** Mass	☐	**N** Neodensity	☐	**S** Single Dilated Duct

Recommendation (check all that apply)	**Both**	**Left**	**Right**
Normal interval follow-up	☐	☐	☐
Additional views	☐	☐	☐
Ultrasound	☐	☐	☐
Short-term follow-up mammography	☐	☐	☐
Fine needle aspiration (including cyst aspiration)	☐	☐	☐
Core biopsy	☐	☐	☐
Consider surgical biopsy	☐	☐	☐
Clinical examination for further diagnostic evaluation	☐	☐	☐