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
   - ☐ 3 Visit
   - ☐ 2 Mail
   - ☐ 8 Other
4. Visit Type:
   - ☐ 1 Screening # __
   - ☐ 2 Semi-Annual # __
   - ☐ 3 Annual # __
   - ☐ 4 Non-Routine

Endometrial Aspiration

5. Date of endometrial aspiration:
   __-__-__ (M/D/Y)
6. Was entry possible?
   - ☐ 1 Yes
   - ☐ 2 No, entry into the uterus was not possible
     → Schedule an ultrasound
   - ☐ 3 No, participant refused
   - ☐ 5 No, D&C results obtained
   - ☐ 4 No, other _____
7. Depth of uterus: __.__ cm
8. Was significant endometrial cavity fluid found?
   - ☐ 0 No
   - ☐ 1 Yes
9. Endometrial Aspiration Report results from *(Mark one)*:
   - ☐ 1 Local lab (for aspiration performed at CC)
   - ☐ 3 Participant's personal M.D. ↘

M.D. Name: _____
Clinic Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

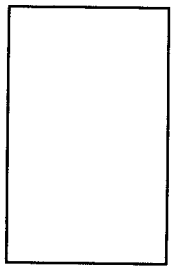
10. Date endometrial aspiration report reviewed:
    __-__-__ (M/D/Y)
11. Report reviewed by: __ _____
12. Summary of endometrial aspiration report: *(Mark the greatest degree of severity found; if 5-10, refer to Clinic Practitioner.)*
    - ☐ 0 No endometrial tissue identified
    - ☐ 1 Insufficient specimen
    - ☐ 2 Normal atrophic endometrium
    - ☐ 3 Normal secretory endometrium
    - ☐ 4 Normal proliferative endometrium
    - ☐ 5 Cystic (simple) hyperplasia present
    - ☐ 6 Cystic (simple) hyperplasia with atypia
    - ☐ 7 Adenomatous (complex) hyperplasia present
    - ☐ 8 Adenomatous (complex) hyperplasia with atypia
    - ☐ 9 Atypia present
    - ☐ 10 Cancer present
    - ☐ 11 Other (_____)
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:
MD/Clinic: _____
Address: _____
_____
Phone: _____
13.4. Follow-up results:
- ☐ 0 Normal
- ☐ 1 Hyperplasia
- ☐ 2 Cancer

Central Lab Review

14. Endometrial Aspiration Slide Number

Slide Number



15. Date Central Lab endometrial aspiration report reviewed:

__-__-__ (M/D/Y)

16. Central Lab report reviewed by:

____ _____

17. Summary of Central Lab endometrial aspiration report: *(Mark the greatest degree of severity found; if 5-10, refer to Clinic Practitioner.)*

- ☐ 0 No endometrial tissue identified
- ☐ 1 Insufficient specimen
- ☐ 2 Normal atrophic endometrium
- ☐ 3 Normal secretory endometrium
- ☐ 4 Normal proliferative endometrium
- ☐ 5 Cystic (simple) hyperplasia present
- ☐ 6 Cystic (simple) hyperplasia with atypia
- ☐ 7 Adenomatous (complex) hyperplasia present
- ☐ 8 Adenomatous (complex) hyperplasia with atypia
- ☐ 9 Atypia present
- ☐ 10 Cancer present
- ☐ 11 Other (_____)