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 _____