COMMENTS:	**- Affix label here-** Participant ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. Contact date: ☐☐-☐☐☐-☐☐☐☐ (M/D/Y)

2. Staff person: ☐☐-☐☐☐☐ _____

3. Date of mammogram: ☐☐-☐☐☐-☐☐☐☐ (M/D/Y)

4. Performed by:

   MD Name: _____

   Clinic Name: _____

   Address: _____

   City/State/Zip: _____

   Phone: _____

5. Date mammogram report reviewed: ☐☐-☐☐☐-☐☐☐☐ (M/D/Y)

6. Report reviewed by: ☐☐-☐☐☐☐ _____

7. Summary of mammogram report *(Mark one in each column)*:

	7.1. **Right**	7.2. **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

RV _____ K _____