

# RADIOLOGIST / TECHNOLOGIST EVALUATION – LONG FORM

Sections with an ‘\*’ are OPTIONAL

**NOTES**

*(check one from each group)*

- \*Comparison films:  No films     No changes  
 Significant changes  
 Films not comparable

- \*Physical findings:  Not available  
 Available, no findings noted  
 Available, findings noted

**1. INDICATION FOR EXAM:** *(check one)*

- Screening (asymptomatic)
- Evaluation of breast problem (symptomatic)
- Additional evaluation of recent mammogram
- Short interval follow-up
- \*Other procedures

**2. TYPE OF EXAM(S) PERFORMED:**

*(check all that apply)*

	B	L	R
Routine views (MLO, CC)			
Standard film screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic (additional) views (i.e., spot compression, magnification, other projections, etc.)			
Standard film screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuclear medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other breast imaging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3. \*OTHER PROCEDURES PERFORMED:**

*(check all that apply)*

	B	L	R
Needle localization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Core biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyst aspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine needle aspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ductogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. Breast density:**

*(check denser breast if left and right differ)*

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

**6. ASSESSMENT:**

	B	L	R
0: Needs additional imaging evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1: Negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2: Benign finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3: Probably benign finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4: Suspicious abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5: Highly suggestive of malignancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7. RECOMMENDATION(S):** *(check all that apply)*

	B	L	R
<b>Next mammogram:</b>			
Normal interval	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*1 year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*2 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Return at age 40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Return at age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short interval	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Immediate Work-up:</b>			
Additional views	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Nuclear medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical exam for further evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgical consult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine needle aspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. DIGITAL MAMMOGRAPHY read by:**

*(check all that apply)*

- Hard copy
- Soft copy

**9. COMPUTER ASSISTED DIAGNOSIS**

**TECHNOLOGY used to read:** *(check all that apply)*

- Routine views
- Diagnostic views