

West Virginia Breast and Cervical Cancer Screening Program Radiology Report

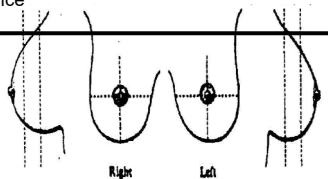
Screening Facility: _____ WVBCSP #: _____

Client Name (Last, First, MI): _____

Social Security: _____-_____-_____ Date of Birth: ____/____/____

Mammography/Ultrasound Facility: _____

Comparison with previous exam: No Yes Date of Previous Exam (mm/dd/yyyy): ____/____/____

MAMMOGRAPHY PROCEDURES	VIEWS TAKEN
<input type="checkbox"/> Additional Mam Views <input type="checkbox"/> Mammogram Date of Breast Procedure (mm/dd/yyyy): ____/____/____	<input type="checkbox"/> Additional View in CC <input type="checkbox"/> Additional View in ML <input type="checkbox"/> Bilateral <input type="checkbox"/> Magnification Spot <input type="checkbox"/> Unilateral-Lt <input type="checkbox"/> Unilateral-Rt <input type="checkbox"/> Spot Compression
INDICATION FOR MAMMOGRAPHY	MAMMOGRAPHY RESULTS
<input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic <input type="checkbox"/> Non-program mammogram, referred in for dx evaluation <input type="checkbox"/> No Mammogram <input type="checkbox"/> No Breast Service	<input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality (Consider Bx) (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Need Evaluation or Film Comparison (BI-RADS 0) <input type="checkbox"/> Result pending <input type="checkbox"/> Result unknown, presumed abnormal, mammogram from non-program funded Date of Mammogram (mm/dd/yyyy): ____/____/____ Paid for by WVBCSP? <input type="checkbox"/> Yes <input type="checkbox"/> No
 <p style="text-align: center;">Right Left</p>	

ULTRASOUND RESULTS
<input type="checkbox"/> Assessment is Incomplete, Need Additional Imaging <input type="checkbox"/> Benign Finding <input type="checkbox"/> Highly Suggestive of Malignancy <input type="checkbox"/> Known Biopsy - Proven Malignancy <input type="checkbox"/> Negative <input type="checkbox"/> Not Done - Other/Unknown Reason <input type="checkbox"/> Probably Benign <input type="checkbox"/> Refused <input type="checkbox"/> Suspicious Abnormality (Consider Bx) Date of Ultrasound (mm/dd/yyyy): ____/____/____ Paid for by WVBCSP? <input type="checkbox"/> Yes <input type="checkbox"/> No

RADIOLOGIST'S RECOMMENDATIONS
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> Additional Mam Views* <input type="checkbox"/> Biopsy* <input type="checkbox"/> CBE by Consult* <input type="checkbox"/> Fine Needle Aspirate (FNA)* <input type="checkbox"/> Follow Routine Screening <input type="checkbox"/> MRI: high-risk ONLY; requires preauthorization* <input type="checkbox"/> Obtain Definitive Rx* <input type="checkbox"/> Repeat Mammogram Immediately* <input type="checkbox"/> Short term follow-up Mam (return in six (6) months) <input type="checkbox"/> Surgical Consult* </div> <div style="width: 35%; border: 1px solid black; padding: 5px; text-align: center;"> Shaded boxes with an * indicate that work-up is necessary. </div> </div>

REQUIRED SIGNATURE
Interpreting Physician's Signature: _____ Date (mm/dd/yyyy): ____/____/____

Please Provide a copy of the mammography/ultrasound narrative to your WVBCSP Tracking and Follow-up Nurse .