WV Breast and Cervical Cancer Screening Program
Radiology Report

Screening Facility: _____ WVBCCSP #: _____

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/yyy): _____ /_____ /_____

MAMMOGRAPHY PROCEDURES

□ Additional Mam Views
□ Mammogram

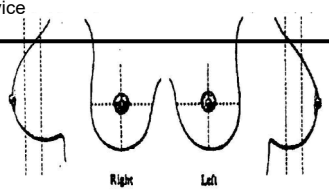
Date of Breast Procedure (mm/dd/yyyy): _____/_____/_____

VIEWS TAKEN

□ Additional View in CC
□ Additional View in ML
□ Bilateral
□ Magnification Spot
□ Unilateral-Lt
□ Unilateral-Rt
□ Spot Compression

INDICATION FOR MAMMOGRAPHY

□ Screening
□ Dignostic
□ Non-program mammogram, referred in for dx evaluation
□ No mammogram
□ No Breast Service



MAMMOGRAPHY RESULTS

□ Negative (BI-RADS 1)
□ Benign Findings (BI-RADS 2)
□ Probably Benign (BI-RADS 3)
□ Suspicious Abnormality (Consider Bx) (BI-RADS 4)
□ Highly Suggestive of Malignancy (BI-RADS 5)
□ Unsatisfactory
□ Need Evaluation or Film Comparison (BI-RADS 0)
□ Result pending
□ Result unknown, presumed abnormal, mammogram from non-program funded

Date of Mammogram (mm/dd/yyyy): _____ /_____ /_____

Paid for by WVBCCSP? □Yes □ No

ULTRASOUND RESULTS

□ Assessment is Incomplete, Need Additional Imaging
□ Benign Finding
□ Highly Suggestive of Malignancy
□ Known Biopsy - Proven Malignancy
□ Negative
□ Not Done - Other/Unknown Reason
□ Probably Benign
□ Refused
□ Suspicious Abnormality (Consider Bx)

Date of Ultrasound (mm/dd/yyyy): _____ /_____ /_____
Paid for by WVBCCSP? □ Yes □No

RADIOLOGIST'S RECOMMENDATIONS

□ Additional Mam Views*
□ Biopsy*
□ CBE by Consult*
□ Fine Needle Aspirate (FNA)*

Shaded boxes with an * indicate that work-up is necessary.

□ Follow Routine Screening

□ MRI: high-risk ONLY; requires preauthorization*
□ Obtain Definitive Rx*
□ Repeat Mammogram Immediately*

□ Short term follow-up Mam (return in six (6) months)

□ Surgical Consult*
□ Ultrasound: *Reimbursement only when performed within one month of mammogram.**

REQUIRED SIGNATURE

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

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