

ACCOUNT # _____

INSURANCE _____

DOCTORS RADIOLOGY CENTER
AVENEL, NJ

TODAY'S DATE _____

MAMMOGRAPHY TRACKING FORM

Patient Information

Name _____ DOB _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Bus. Phone _____

Referring MD _____

Referring MD Address _____

Reason for Exam

_____ Screening _____ Personal Hx Breast Ca _____ Family Hx Breast Ca

_____ Pain _____ Painful Nodule R L

Mammo FU _____ Other _____

Diagnosis

Radiologist # _____

Diagnostic Category: _____

0= Incomplete study; additional imaging or
Old studies needed.

1= Negative

2= Benign Disease

3= Indeterminate - Probably Benign

4 = Suspicious for Malignancy

5 = Malignant

Suggested Follow Up

_____ Routine Mammogram _____ 4-6 Month Mammogram _____ 3-4 Month Mammogram

_____ Additional Views _____ Previous Films for Comparison

_____ Ultrasound _____ Other

_____ Biopsy

_____ Notification of MD By Whom: _____

Results

_____ Follow-up Mammogram Findings _____

_____ Follow-up Ultrasound Findings _____

_____ Biopsy Performed Date _____ Surgeon _____

Pathology: _____ Benign _____ Malignant _____ Indeterminate

Pathology Report: _____