FORM: **85 - MAMMOGRAM**

Version: 3.1 - February 17, 1995

Description: Completed by Clinic Practitioner (CP); 1-page form; key-entered at Clinical Center (CC).

When used: During screening (usually Screening Visit 2 [SV2]), annual visits, and non-routine visits for evaluations of the breast.

Purpose: To record results of mammograms and any resulting referrals.

GENERAL INSTRUCTIONS

1. Include form in the screening and appropriate annual visit participant packets. Use as needed for non-routine evaluations.

2. Affix a participant barcode label to the form.

3. At the contact, complete Items 1 - 4.

4. Determine if you need to request the results of a previous mammogram or ask the participant to schedule a mammogram. If you need to request the results of a mammogram, record the name and address of the facility in Item 6. If you are scheduling a mammogram, record the name and address of the facility that will perform the mammogram.

5. Request the report.

6. When you receive the report from the radiologist, complete Items 5 and 7 - 10.

7. Process and key-enter the form in the manner that best fits the flow of your CC. Options include:

    - Key-enter Items 1 - 4 to initiate the form in the database and key-enter the remainder of the form after receiving the mammogram report: To do this:

        - Send the form to Data Entry after completing Items 1 - 4 and requesting a copy of the mammogram or referring the participant for mammography. Store the form in the participant file or a central holding area to await the report.

        - When you receive the report, complete the remainder of the form, attach the report to the form. Send the form to Data Entry for key-entry of the remainder of the form.

    - Key-enter the *entire* form after receiving the mammogram results. To do this:

        - Store the form in the participant's file or in a central holding area with other "waiting for results" forms.

        - When you receive the report, complete the remainder of the form, and attach the report to the form. Send the form to Data Entry for key-entry.

8. Data Entry: Regardless of which processing option is chosen, review the form for completeness and return to the responsible clinical staff person with any problems or questions. Key-enter after you resolve any questions.

   Initial the first page of the form when you complete the key-entry. If you key-enter the form before the report is returned, initial the form as key-entered twice, once when you key-enter Items 1 - 4 and again when you key-enter the mammogram results.

9. After key-entry, file both the form and mammogram report in the participant's file.

Item Instructions

1.	Contact date	Date the form is initiated.
2.	Staff person	Standard 3-digit WHI employee ID. (See common data items.) Data Entry: Name is not key-entered.
3.	Contact type	Mark appropriate box. (See common data items.)
4.	Visit type	Contact at which form is initiated or most recent past visit. Mark appropriate box. Provide visit number as appropriate. (See common data items.)
5.	Date of mammogram	Date the mammogram was performed. Record the date of the mammogram from the mammogram report.
6.	Performed by	Name of MD, clinic name, address, and phone number of who performed the mammogram. Data Entry: Name and address not key-entered.
7.	Date reviewed	Date CC CP reviewed the mammogram report.
8.	Reviewed by	Standard 3-digit WHI employee ID of CC CP who reviewed the mammogram report and completed Item 6.5. (See common data items.) Data Entry: Name is not key-entered.
9.	Summary	Summary of the mammogram report. Mark the appropriate box for both right and left. If multiple diagnoses are given, mark the box corresponding to the diagnosis of greatest severity. If "3 - Suspicious abnormality" or "4 - Highly suggestive of malignancy" is marked for either side, the woman is ineligible for DM or HRT, unless Item 12 - Final follow-up results is marked "1 - Normal/benign changes." If the participant has had a mastectomy or bilateral mastectomies, mark “not done” on the appropriate sides(s) and document the reason on the form.
10.	Referral for follow-up	No/Yes. If “Yes” document the reason for the referral directly onto the form. If you are using a woman's previous mammogram for baseline screening and it required a referral, mark "1 - Yes."
10.1.	Referred by	Standard 3-digit WHI employee ID. (See common data items.) If referred by primary care provider, use code for "outside employee." Write name on line. (See common data items.) Data Entry: Name is not key-entered.
10.2.	Date of referral	Date the participant referred for follow-up care.

10.3.	Referred to	Name, address, and phone number of person to whom you referred the participant. (Use margin as needed.) Data Entry: Do not key-enter name and address.
11.	Repeat recommended	Mark appropriate box to indicate recommended time for repeat mammogram. If "1 - Immediately/ASAP" is marked, the woman is ineligible for DM and HRT unless Item 12 - Final follow-up results is marked "1 - Normal/benign changes." If no recommendation for the next mammogram is indicated on the report, mark the response that follows study protocol (“one year” for HRT participants, “two years” for DM participants).
12.	Final follow-up	Mark appropriate box for either right or left side to document results of the referred work-up. Document directly onto the form the follow-up procedure(s) used, the date(s), and any results. If "1 - Normal/benign changes" is marked, the woman is eligible for DM or HRT, even if Item 9 - Summary of mammogram indicated she was ineligible or Item 11 - Repeat mammogram was marked "1 - Immediately/ASAP." If "2 - Possible malignant" or "3 - Cancer" is marked, the woman is ineligible for both DM and HRT.