

國民健康署婦女乳房攝影檢查異常個案報告表

病歷號：_____。

檢查資訊									
姓名	身分證統一編號								
				護照號碼(外籍人士)					
出生日期	_____年_____月_____日			乳房攝影日期	_____年_____月_____日				
醫院名稱				放射科醫師					
乳房 X 光攝影陽性結果									
<input type="checkbox"/> Category 0: Need Additional Imaging Evaluation. <input type="checkbox"/> Category 3: Probably Benign Finding – Short Interval Follow-up Is Suggested. <input type="checkbox"/> Category 4: Suspicious Abnormality – Biopsy Should Be Considered. <input type="checkbox"/> a. Low suspicion ; <input type="checkbox"/> b. Intermediate suspicion ; <input type="checkbox"/> c. Moderate suspicion <input type="checkbox"/> Category 5: Highly Suggestive Of Malignancy – Appropriate Action Should Be Taken.									
病灶勾選									
<input type="checkbox"/> 1. Mass: <input type="checkbox"/> Rt. <input type="checkbox"/> Lt. <input type="checkbox"/> Multiple, Unilateral <input type="checkbox"/> Multiple, Bilateral									
Location	<input type="checkbox"/> UOQ <input type="checkbox"/> UIQ <input type="checkbox"/> LOQ <input type="checkbox"/> LIQ <input type="checkbox"/> Subareolar <input type="checkbox"/> Axillary tail		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere				
	One view only		<input type="checkbox"/> Outer Hemisphere		<input type="checkbox"/> Inner Hemisphere				
Size	<input type="checkbox"/> < 1.0 cm <input type="checkbox"/> 1-2 cm <input type="checkbox"/> 2-3 cm <input type="checkbox"/> 3-4 cm <input type="checkbox"/> > 4 cm								
Shape	<input type="checkbox"/> Round <input type="checkbox"/> Oval <input type="checkbox"/> Lobular <input type="checkbox"/> Irregular								
Margins	<input type="checkbox"/> Circumscribed <input type="checkbox"/> Microlobulated <input type="checkbox"/> Obscured <input type="checkbox"/> Indistinct <input type="checkbox"/> Spiculated								
Density	<input type="checkbox"/> High-density <input type="checkbox"/> Isodense <input type="checkbox"/> Low-density <input type="checkbox"/> Radiolucent <input type="checkbox"/> Mixed density								
<input type="checkbox"/> 2. Calcifications: <input type="checkbox"/> Rt. <input type="checkbox"/> Lt. <input type="checkbox"/> Multiple, Unilateral <input type="checkbox"/> Multiple, Bilateral									
Location	<input type="checkbox"/> UOQ <input type="checkbox"/> UIQ <input type="checkbox"/> LOQ <input type="checkbox"/> LIQ <input type="checkbox"/> Subareolar <input type="checkbox"/> Axillary tail		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere				
	One view only		<input type="checkbox"/> Outer Hemisphere		<input type="checkbox"/> Inner Hemisphere				
Distribution	<input type="checkbox"/> Cluster <input type="checkbox"/> Linear <input type="checkbox"/> Segmental <input type="checkbox"/> Regional <input type="checkbox"/> Diffuse								
Morphology	<input type="checkbox"/> Amorphous <input type="checkbox"/> Coarse Heterogeneous <input type="checkbox"/> Pleomorphic <input type="checkbox"/> Fine Linear Branching								
<input type="checkbox"/> 3. Focal Asymmetry: <input type="checkbox"/> Rt. <input type="checkbox"/> Lt.									
Location	<input type="checkbox"/> UOQ <input type="checkbox"/> UIQ <input type="checkbox"/> LOQ <input type="checkbox"/> LIQ <input type="checkbox"/> Subareolar <input type="checkbox"/> Axillary tail		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere				
	One view only		<input type="checkbox"/> Outer Hemisphere		<input type="checkbox"/> Inner Hemisphere				
<input type="checkbox"/> 4. Architectural Distortion: <input type="checkbox"/> Rt. <input type="checkbox"/> Lt.									
Location	<input type="checkbox"/> UOQ <input type="checkbox"/> UIQ <input type="checkbox"/> LOQ <input type="checkbox"/> LIQ <input type="checkbox"/> Subareolar <input type="checkbox"/> Axillary tail		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere				
	One view only		<input type="checkbox"/> Outer Hemisphere		<input type="checkbox"/> Inner Hemisphere				
<input type="checkbox"/> 5. Thickening or retraction of the skin and/or nipple: <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.									
<input type="checkbox"/> 6. Dense or enlarged axillary LNs: <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.									
<input type="checkbox"/> 7. Dilated lactiferous ducts: <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.									
<input type="checkbox"/> 8. Diffuse thickening of the skin and increased density: <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.									
<input type="checkbox"/> 9. Others: _____。									