

## 婦女乳房攝影檢查異常個案報告表

病歷號：\_\_\_\_\_

檢查資訊										
姓名	身分證字號									
				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"/> <b>Category 0:</b> Need Additional Imaging Evaluation. <input type="checkbox"/> <b>Category 3:</b> Probably Benign Finding – Short Interval Follow-up Is Suggested. <input type="checkbox"/> <b>Category 4:</b> 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"/> <b>Category 5:</b> Highly Suggestive Of Malignancy – Appropriate Action Should Be Taken.										
病灶勾選										
<input type="checkbox"/> <b>1. Mass:</b> <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					
	One view only		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere					
			<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"/> <b>2. Calcifications:</b> <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					
	One view only		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere					
			<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"/> <b>3. Focal Asymmetry:</b> <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					
	One view only		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere					
			<input type="checkbox"/> Outer Hemisphere		<input type="checkbox"/> Inner Hemisphere					
<input type="checkbox"/> <b>4. Architectural Distortion:</b> <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					
	One view only		<input type="checkbox"/> Upper Hemisphere		<input type="checkbox"/> Lower Hemisphere					
			<input type="checkbox"/> Outer Hemisphere		<input type="checkbox"/> Inner Hemisphere					
<input type="checkbox"/> <b>5. Thickening or retraction of the skin and/or nipple:</b> <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.										
<input type="checkbox"/> <b>6. Dense or enlarged axillary LNs:</b> <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.										
<input type="checkbox"/> <b>7. Dilated lactiferous ducts:</b> <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.										
<input type="checkbox"/> <b>8. Diffuse thickening of the skin and increased density:</b> <input type="checkbox"/> Rt./ <input type="checkbox"/> Lt.										
<input type="checkbox"/> <b>9. Others:</b> _____										