Mammography Documentation Best Practices

Document Goals: Site mammography technologists should utilize this guide to ensure effective communication of relevant information to interpreting radiologists. Proper documentation of information allows physicians to provide patients with accurate and complete mammography results.

Information To Always Document in Imagen PACS

- "Routine" if the exam is an annual screening or "Baseline" if exam is the patient's first mammogram ●

Patient concerns ("No concerns" if none exist)

- Availability of priors ("Priors unavailable, Priors available in PACs or Priors requested." Include year of priors if known.)

Additional Information to Document (When Applicable)

- Year of previous mammogram
- Abnormalities, visual or otherwise, noted by technologist
- Previous biopsy (specify laterality, year and results) or augmentation/reduction/lift
- Patient history of breast or ovarian cancer (specify laterality, year and treatment)
- Family history of breast or ovarian cancer (include relationship and relative age at diagnosis) ●

Additional images acquired to complete the study

- Patient refusal of imaging, limitations such as disabilities or inability to tolerate compression that affect image quality
- BRCA gene if tested/available

NOTE: Due to character limitations of the "Additional Information" field in Imagen's PACs, we strongly recommend using acceptable medical abbreviations to keep notes as concise as possible.

Intake Form Documentation

- All intake form questions must be answered to the best of each patient's ability. Technologists should review this form prior to beginning a study and gather any missing information from the patient. Enter "N/A" for any question that is not applicable.
- Whenever possible, note scars, moles and any areas of concern (duration and description) on intake form diagram
    - If electronic intake form is used and no editable diagram is available, skin markers should be used to indicate moles, scars and other areas of concern.