MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
LOCAL FORM TITLE *(Optional)*	

BREAST EXAM DOCUMENTATION FOR RADIATION MEDICAL SURVEILLANCE EXAM

Findings:

NORMAL_____ ABNORMAL_____

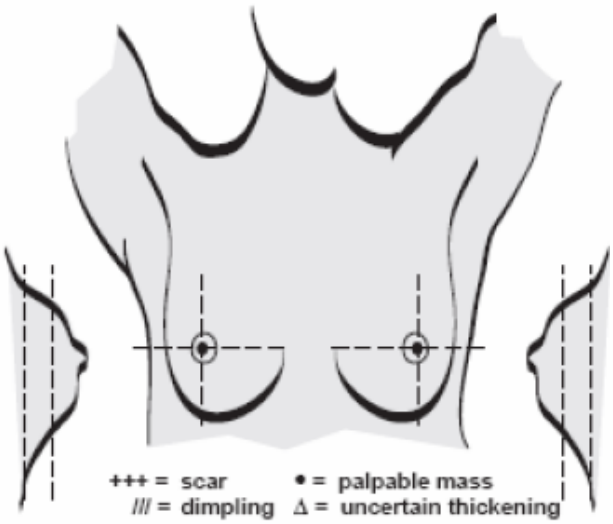
If **ABNORMAL ,** please check any that apply and annotate on the figure provided.

MASS ( )

NIPPLE DISCHARGE ( )

SKIN RETRACTION ( )

OTHER:



Clinician name/ Stamp:

Signature:

Date:

Note: Please provide this to patient to hand carry and present at the time of her scheduled appointment.

Thank You
Officer in Charge
BHC Puget Sound Naval Shipyard

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

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