



GRANT RECIPIENT BREAST HEALTH REPORT

DATE From: _____ To: _____

Recipient Organization

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT	OCTOBER	NOV	DEC	TOTAL
--	-----	-----	-------	-------	-----	------	------	--------	------	---------	-----	-----	-------

Mammograms

Screening													
Diagnostic													
TOTAL													

Additional Imaging													
Ultrasound													
Surgical Consultation													
Other													
TOTAL													

Needle Aspiration													
Biopsy													
TOTAL													

Prepared By: _____ **Date Submitted:** _____

Inland Empire Affiliate

Phone: _____ **Email:** _____

Effective Date April 1, 2010