**IMAGING BREAST EVALUATION REPORTING FORM**

# Please Print Clearly BCCHP#       Authorization #

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **R**  **E**  **F**  **E**  **R**  **R**  **A**  **L**  **S**  **O**  **U**  **R**  **C**  **E** | CLIENT NAME (Last, First, MI) | | | | | | | DATE OF BIRTH | | | LAST FOUR SS# (optional) | | | | DATE OF PROCEDURE | | |
| IMAGING FACILITY/SITE | | | | | PREVIOUS IMAGING FACILITY/DATE (COMPARISON)\* | | | | | | | | CHART NUMBER | | | |
| REFERRING CLINIC SITE | | | | | | | | | | | | | REFERRING PROVIDER NAME | | | |
| PRIMARY INSURANCE (IF THERE IS A PRIMARY INSURANCE COVERAGE, PLEASE SUBMIT EOB TO BCCHP FOR ADDITIONAL REIMBURSEMENT UP TO PROGRAM FEE SCHEDULE AMOUNT)  Name of insurance company       Policy/Identification number | | | | | | | | | | | | | | | | |
| Type of test ordered:Screening:  Mammography  MRI\* \*Approval for high-risk screening MRI requires prior authorization and lifetime risk calculation. **If available, please complete below:**  Was the Tyrer-Cuzick (IBIS) model used? \_\_\_\_Yes \_\_\_\_ No  If so, Lifetime Risk: \_\_\_\_\_\_\_\_%(20% or higher is considered high risk)   * Family history of breast cancer:  Yes  No   If yes, Relative type:       Age at dx:   * Positive for BRCA mutation, or first-degree relative  Yes  No  Diagnostic:  R  L  Bilateral  Mammography  Ultrasound **Personal history of breast cancer**:  Yes  No, Age at dx:  **Breast Implants**  Yes  No  **Ordering Clinician’s Remarks:** | | | | | | | | | | RightLeft   ***A mammogram (or additional mammographic views) is not sufficient evaluation of an abnormal CBE.***  ***Palpable breast masses need to be evaluated clinically and/or with ultrasound regardless of mammogram result.*** | | | | | | |
|  | FOR IMAGING FACILITY USE ONLY BELOW THIS LINE | | | | | | | | | | | | | | | | |
|  | **Type of Test** | | | | Mammography  Digital | | Conventional | | |  | | US | | | | MRI | |
|  | **Mam** | | **US** | |  | | | | | | | | | | | | |
|  | **L** | **R** | **L** | **R** |  | | | | | | | | | | | | |
| **BI-RADS Results** |  |  |  |  | (1) Negative – The breast(s) are symmetric with no masses, architectural distortion or suspicious calcifications present. | | | | | | | | | | | | |
|  |  |  |  | **(2)** **Benign** – There is nothing to suggest cancer; benign findings that warrant reporting. No evidence of malignancy. | | | | | | | | | | | | |
|  |  |  |  | **(3) Probably Benign** – Short Interval Follow-up recommended | | | | | | | | | | | | |
|  |  |  |  | **(4) Suspicious Abnormality** – Lesions do not have specific characteristics of breast cancer but have a possibility of being malignant. The radiologist has sufficient suspicion to warrant biopsy. | | | | | | | | | | | | |
|  |  |  |  | **(5) Highly Suggestive of Malignancy** – These lesions have a high probability of malignancy. | | | | | | | | | | | | |
|  |  |  |  | **(0) Assessment is Incomplete** – Need additional evaluation.  (Assessment Incomplete for a mammogram applies only if additional radiological studies are needed) | | | | | | | | | | | | |
|  |  |  |  | **Technically Unsatisfactory** – Could not be interpreted (needs to be repeated) | | | | | | | | | | | | |
| **Recom-mendations** | Additional Mammographic Views  Surgical Consult / Repeat Breast Exam  Ultrasound  Short Interval Follow-up Suggested in       months  Fine Needle Aspiration  Routine Screening Mammogram  Biopsy  Obtain Prior Films for Comparison\* | | | | | | | | | | | | | | | | |
|  | **COMMENTS:** | | | | | | | | | | | | | | | | |
|  | DIAGNOSTIC PROVIDER SIGNATURE | | | | | | | | Print Name | | | | Telephone Number | | | | Date |

**Please FAX form to the BCCHP Prime Contractor at:**