**Breast Diagnostic Form**

**BCCHP ID#:** **Authorization #:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME (Last, First, MI) | | | | | DATE OF BIRTH | | SOCIAL SECURITY NUMBER | | | DATE OF PROCEDURE | |
| REFERRING PROVIDER/CLINIC SITE | | | SPECIALTY CLINIC SITE | | | | PLACE OF SERVICE  Office  Hospital  ASC | | | CHART NUMBER | |
| Referred for diagnostic evaluation by non-BCCHP  provider on date: | | | SPECIALTY PROVIDER NAME | | | |
| **Surgical Consult / Repeat Clinical Breast Exam** CBE Result: Normal Abnormal - Findings  Recommendation:  **Breast Cancer Risk:**  Average  High  Not Assessed **Indicate if chest wall radiation before 30**  Yes  No  I**f high risk,** Tyrer-Cuzick (IBIS) model used**:**  Yes  No Other tool used(Gail model not accepted by BCCHP):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Lifetime Risk:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%** (20% or higher is considered high risk) | | | | | | | | | | | |
| Procedures & Results | |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Which Breast:** | Left | Right | | | | |  | | |  | | | | **Ultrasound** | Neg | Benign | | | | | Probably Benign | | | Suspicious Abnormality | | | | Highly Suggest Malig | | | Assess Incomplete | | | | Tech Unsatisfactory | | |  | | | **Breast Smear** | Neg Malig | | Pos Malig | | Indeterm/ Atyp | | | | Non-Diag / Needs rpt | | | No Specimen | | **Biopsy** | Neg Malig | | Pos Malig | | Indeterm/ Atyp | | | | Non-Diag / Needs rpt | | | No Specimen | | ***Type of Biopsy:*** | Percutaneous | | Open | | | Skin | | |  | | | | | **Type of Localization Guidance:** | Mammogram | | Ultrasound | | | MRI | | |  | | | | | **FNA** | Neg Malig | | Pos Malig | | | Indeterm/ Atyp | | | Non-Diag / Needs rpt | | | No Specimen | | ***Imaging:*** | Yes | | No Type: | | |  | | |  | | | | | **Cyst Aspiration** | Neg Malig | | Pos Malig | | | Indeterm/ Atyp | | | Non-Diag / Needs rpt | | | No Specimen | | **Ducto/Galactogram** | Neg Malig | | Pos Malig | | | Indeterm/ Atyp | | | Non-Diag / Needs rpt | | | No Specimen | | | | | | | | | | | |
| **Final Dx/Status** | Not Cancer  Lobular Carcinoma In Situ\*  Ductal Carcinoma In Situ\*  Cancer Invasive\*  Atypical Hyperplasia\*  **\**If diagnosed with these diagnoses, contact BCCHP to enroll in the Breast and Cervical Cancer Treatment Program (BCCTP)*** | | | | | | | | | | |
| Work-up complete – Date:        Recommended follow-up:  Work-up pending – Date:        Why Pending:  \*\*Lost to follow-up – Date:        Why Lost:  \*\*Work-up refused – Date:        Why Refused:  ***\*\* Provide documentation to BCCHP Prime Contractor of attempts to contact client*** | | | | | | | | | | |
| **Treatment recommended**:  Date: | Axillary Dissection | | | | Sentinel Node Biopsy | | | Lumpectomy | | |
| Mastectomy :  Radical  Modified | Chemotherapy | | | | Radiation | | | Endocrine Therapy | | |
| **If referred for treatment, treatment clinical site/provider:** | | | | | | | | | | |
| DIAGNOSTIC PROVIDER SIGNATURE | | | | Print Name | | | | Telephone Number | | | Date |

**PLEASE FAX FORM TO BCCHP PRIME CONTRACTOR AT:**