Washington State Department of Health
DOH 345-211 July 2019

INSERT PRIME CONTRACTOR INFORMATION

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

# 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***

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| | | | | |
|---|---|---|---|---|
| | **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:**