Washington State Department of Health
DOH 345-216 Jan 2016

SPOKANE REGIONAL HEALTH DISTRICT
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WWW.SRHD.ORG

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

BREAST & CERVICAL CANCER TREATMENT PROGRAM TRACKING FORM

Please Print Clearly

Client Last Name	Client First Name	MI	Social Security Number:	Date of Birth:

BCCHP Prime Contractor:	BCCHP ID #	Client Medicaid ID #:

Provider Name:	Clinic Name :	Clinic Chart #:

☐ BREAST Diagnosis Date: _____

- ☐ **Unsp. Benign dysplaisa** ☐ Dx code: **N60.99**
  (*not available for AEM/ERSO - undocumented)*
- ☐ **Unsp. Type Carcinoma in situ (right)** ☐ Dx code: **D05.91**
- ☐ **Unsp. Type Carcinoma in situ (left)** ☐ Dx code: **D05.92**
- ☐ **Malignant Neoplasm (right)** ☐ Dx code: **C50.911**
- ☐ **Malignant Neoplasm (left)** ☐ Dx code: **C50.912**
- ☐ **Other** _____ ☐ Dx code: _____
- ☐ **Metastatic disease**

Current Treatment Plan - BREAST:

- ☐ **Office Visit to initiate staging and treatment plan**
- ☐ **Chemotherapy**
- ☐ **Radiation**
- ☐ **Endocrine therapy:** _____
- ***Start date:*** __ ***Proposed End date*** _
- ☐ **Surgery:** ☐ **Excision** ☐ **Lumpectomy**
- ☐ **Surgery: Mastectomy:** ☐ **Modified** ☐ **Radical**
- ☐ **Surgery: Reconstruction**
  (not available for AEM/ERSO- undocumented)

☐ CERVICAL Diagnosis Date: _____

- ☐ **Moderate Cervical Dysplasia** ☐ Dx code: **N87.1**
  (*not available for AEM/ERSO - undocumented)*
- ☐ **Carcinoma in situ endocervix** ☐ Dx code: **D06.0**
- ☐ **Carcinoma in situ exocervix** ☐ Dx code: **D06.1**
- ☐ **Malignant Neoplasm** ☐ Dx code: **C53.9**
- ☐ **Metastatic disease**

Current Treatment Plan - CERVICAL:

- ☐ **LEEP**
- ☐ **Cone**
- ☐ **Cryo**
- ☐ **Hysterectomy**
- ☐ **Chemotherapy**
- ☐ **Radiation**

Treatment Status: Current Tx start date: _____ Tx complete date: _____

Tx suspended date: _____ ☐ **Declines/refuses Tx** ☐ **Lost to follow-up (**no shows, didn't make appts)

Treatment Comments / Follow-up Plan:

Provider (signature): _____ **Date:**_____ **NPI #** _____

Provider Name (print): _____ **Phone:**_____ **Medicaid #** _____

FOR BCCHP CASE MANAGER USE:

- ☐ **AEM/ERSO eligible only**
- ☐ **New enrollment**
- ☐ **Renewal – client continues active treatment**
- ☐ **Other:**_____

BCCHP Case Manager:

Name:

Phone: **Fax:**

- ☐ **No longer eligible for BCCTP (S30):**
  - ☐ **All cancer treatment completed**
  - ☐ **Now eligible for Apple Health**
  - ☐ **Now eligible for Medicare**
  - ☐ **Has other Creditable Insurance**
  - ☐ **Moving out of state to:** _____
    - ☐ **Transfer to BCCTP there**

Case Manager Signature: _____ **Date:** _____