

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 <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ASC	CHART NUMBER
Referred for diagnostic evaluation by non-BCCHP provider on date:	SPECIALTY PROVIDER NAME			
<input type="checkbox"/> Surgical Consult / Repeat Clinical Breast Exam CBE Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal - Findings Recommendation:				

Procedures & Results	Which Breast:	<input type="checkbox"/> Left	<input type="checkbox"/> Right			
	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Neg	<input type="checkbox"/> Benign	<input type="checkbox"/> Probably Benign	<input type="checkbox"/> Suspicious Abnormality	
		<input type="checkbox"/> Highly Suggest Malig	<input type="checkbox"/> Assess Incomplete	<input type="checkbox"/> Tech Unsatisfactory		
	<input type="checkbox"/> Breast Smear	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt	<input type="checkbox"/> No Specimen
	<input type="checkbox"/> Biopsy	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt	<input type="checkbox"/> No Specimen
	Type of Biopsy:	<input type="checkbox"/> Percutaneous	<input type="checkbox"/> Open	<input type="checkbox"/> Skin		
	Type of Localization Guidance:	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> MRI		
	<input type="checkbox"/> FNA	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt	<input type="checkbox"/> No Specimen
	Imaging:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
	<input type="checkbox"/> Cyst Aspiration	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt	<input type="checkbox"/> No Specimen
<input type="checkbox"/> Ducto/Galactogram	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt	<input type="checkbox"/> No Specimen	

Final Dx/Status	<input type="checkbox"/> Not Cancer <input type="checkbox"/> Lobular Carcinoma In Situ* <input type="checkbox"/> Ductal Carcinoma In Situ* <input type="checkbox"/> Cancer Invasive* <input type="checkbox"/> Atypical Hyperplasia* *If diagnosed with these diagnoses, contact BCCHP to enroll in the Breast and Cervical Cancer Treatment Program (BCCTP)			
	<input type="checkbox"/> Work-up complete – Date:	Recommended follow-up:		
	<input type="checkbox"/> Work-up pending – Date:	Why Pending:		
	<input type="checkbox"/> **Lost to follow-up – Date:	Why Lost:		
	<input type="checkbox"/> **Work-up refused – Date:	Why Refused:		
** Provide documentation to BCCHP Prime Contractor of attempts to contact client				
Treatment recommended:	<input type="checkbox"/> Axillary Dissection	<input type="checkbox"/> Sentinel Node Biopsy	<input type="checkbox"/> Lumpectomy	
Date:				
Mastectomy : <input type="checkbox"/> Radical <input type="checkbox"/> Modified	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Radiation	<input type="checkbox"/> 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: 509-324-1599