Washington State Department of Health
DOH 345-211 June 2019

SPOKANE REGIONAL HEALTH DISTRICT
PHONE 509-323-2851 FAX 509-324-1599
WWW.SRHD.ORG

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			
☐ **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: 509-324-1599

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY call 711)