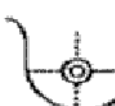
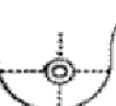


**IMAGING BREAST EVALUATION REPORTING FORM**

Please Print Clearly

BCCHP#

Authorization #

REFERRAL SOURCE	CLIENT NAME (Last, First, MI)	DATE OF BIRTH	LAST FOUR SS# (optional)	DATE OF PROCEDURE
	IMAGING FACILITY/SITE	PREVIOUS IMAGING FACILITY/DATE (COMPARISON)*		CHART NUMBER
	REFERRING CLINIC SITE			REFERRING PROVIDER NAME
	PRIMARY INSURANCE (IF THERE IS A PRIMARY INSURANCE COVERAGE, PLEASE SUBMIT EOB TO BCCHP FOR ADDITIONAL REIMBURSEMENT UP TO PROGRAM FEE SCHEDULE AMOUNT) Name of insurance company			
	Policy/Identification number			
	<b>Type of test ordered:</b> <b>Screening:</b> <input type="checkbox"/> Mammography <input type="checkbox"/> MRI* *Approval for high-risk screening MRI requires prior authorization and lifetime risk calculation. <b>If available, please complete below:</b> Was the Tyrer-Cuzick (IBIS) model used? ___ Yes ___ No If so, Lifetime Risk: _____% (20% or higher is considered high risk)		<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p><b>Right</b></p>  </div> <div style="text-align: center;"> <p><b>Left</b></p>  </div> </div> <p><b>A mammogram (or additional mammographic views) is not sufficient evaluation of an abnormal CBE. Palpable breast masses need to be evaluated clinically and/or with ultrasound regardless of mammogram result.</b></p>	
	• Family history of breast cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Relative type: _____ Age at dx: _____ • Positive for BRCA mutation, or first-degree relative <input type="checkbox"/> Yes <input type="checkbox"/> No			
	<b>Diagnostic:</b> <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Mammography <input type="checkbox"/> Ultrasound			
	<b>Personal history of breast cancer:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, Age at dx: _____ <b>Breast Implants</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Ordering Clinician's Remarks:</b>			

**FOR IMAGING FACILITY USE ONLY BELOW THIS LINE**

<b>Type of Test</b>		<input type="checkbox"/> Mammography <input type="checkbox"/> Digital <input type="checkbox"/> Conventional		<input type="checkbox"/> US	<input type="checkbox"/> MRI
<b>Mam</b>		<b>US</b>			
<b>L</b>	<b>R</b>	<b>L</b>	<b>R</b>		
BI-RADS Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(1) Negative</b> – The breast(s) are symmetric with no masses, architectural distortion or suspicious calcifications present.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(2) Benign</b> – There is nothing to suggest cancer; benign findings that warrant reporting. No evidence of malignancy.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(3) Probably Benign</b> – Short Interval Follow-up recommended
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(4) Suspicious Abnormality</b> – Lesions do not have specific characteristics of breast cancer but have a possibility of being malignant. The radiologist has sufficient suspicion to warrant biopsy.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(5) Highly Suggestive of Malignancy</b> – These lesions have a high probability of malignancy.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(0) Assessment is Incomplete</b> – Need additional evaluation. (Assessment Incomplete for a mammogram applies only if additional radiological studies are needed)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Technically Unsatisfactory</b> – Could not be interpreted (needs to be repeated)
Recom-	<input type="checkbox"/> Additional Mammographic Views		<input type="checkbox"/> Surgical Consult / Repeat Breast Exam		
	<input type="checkbox"/> Ultrasound		<input type="checkbox"/> Short Interval Follow-up Suggested in _____ months		
	<input type="checkbox"/> Fine Needle Aspiration		<input type="checkbox"/> Routine Screening Mammogram		
	<input type="checkbox"/> Biopsy		<input type="checkbox"/> Obtain Prior Films for Comparison*		
<b>COMMENTS:</b>					
DIAGNOSTIC PROVIDER SIGNATURE		Print Name		Telephone Number	Date

Please FAX form to the BCCHP Prime Contractor at: