Washington State Department of Health

DOH 345-212 July 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

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

Type of test ordered:

Screening: ☐ Mammography ☐ MRI*

*Approval for high-risk screening MRI requires prior authorization and lifetime risk calculation. **If available, please complete below:**

Was the Tyrer-Cuzick (IBIS) model used? ____Yes ____ No

If so, Lifetime Risk: _____% (20% or higher is considered high risk)

- Family history of breast cancer: ☐ Yes ☐ No
  If yes, Relative type: Age at dx:
- Positive for BRCA mutation, or first-degree relative ☐ Yes ☐ No

Diagnostic: ☐ R ☐ L ☐ Bilateral ☐ Mammography ☐ Ultrasound

Personal history of breast cancer: ☐ Yes ☐ No, Age at dx:
Breast Implants ☐ Yes ☐ No
Ordering Clinician's Remarks:

Right **Left**

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.

FOR IMAGING FACILITY USE ONLY BELOW THIS LINE

Type of Test	☐ **Mammography** ☐ **Digital** ☐ **Conventional**	☐ **US**	☐ **MRI**

Mam		**US**		
L	**R**	**L**	**R**	
☐	☐	☐	☐	**(1) Negative** – The breast(s) are symmetric with no masses, architectural distortion or suspicious calcifications present.
☐	☐	☐	☐	**(2) Benign** – There is nothing to suggest cancer; benign findings that warrant reporting. No evidence of malignancy.
☐	☐	☐	☐	**(3) Probably Benign** – Short Interval Follow-up recommended
☐	☐	☐	☐	**(4) Suspicious Abnormality** – Lesions do not have specific characteristics of breast cancer but have a possibility of being malignant. The radiologist has sufficient suspicion to warrant biopsy.
☐	☐	☐	☐	**(5) Highly Suggestive of Malignancy** – These lesions have a high probability of malignancy.
☐	☐	☐	☐	**(0) Assessment is Incomplete** – Need additional evaluation. (Assessment Incomplete for a mammogram applies only if additional radiological studies are needed)
☐	☐	☐	☐	**Technically Unsatisfactory** – Could not be interpreted (needs to be repeated)

BI-RADS Results

Recom-

☐ Additional Mammographic Views
☐ Ultrasound
☐ Fine Needle Aspiration
☐ Biopsy
☐ Surgical Consult / Repeat Breast Exam
☐ Short Interval Follow-up Suggested in months
☐ Routine Screening Mammogram
☐ Obtain Prior Films for Comparison*

COMMENTS:

DIAGNOSTIC PROVIDER SIGNATURE	Print Name	Telephone Number	Date

Please FAX form to the BCCHP Prime Contractor at:

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