



Breast Screening and Diagnostic Form
Every Woman's Life- Virginia Department of Health

Last Name	First Name	MI	Maiden Name
Admin Site	<input type="checkbox"/> New Screen <input type="checkbox"/> Follow-Up <input type="checkbox"/> Rescreen		SSN (or alien ID)
1. Indication for initial mammogram: <input type="checkbox"/> Routine screening mammogram <input type="checkbox"/> Initial mammogram performed to evaluate symptoms, positive CBE result, or previous abnormal mammogram result <input type="checkbox"/> Initial mammogram done by a non-program funded provider, client referred in for diagnostic evaluation. <input type="checkbox"/> Initial mammogram not done. Client proceeded directly for other imaging or diagnostic work-up. Date client was referred into program for breast diagnostic workup: ____/____/____ <input type="checkbox"/> Unknown			
CLINICAL BREAST EXAM (CBE)		MAMMOGRAM	
2. Does the client have breast symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Did the client have a CBE? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. CBE date: ____/____/____ (mm/dd/yyyy) 5. What were the CBE results? <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding (includes fibrocystic changes, diffuse lumpiness or nodularity) <input type="checkbox"/> Discrete palpable mass* <input type="checkbox"/> Bloody or serous nipple discharge* <input type="checkbox"/> Nipple or areolar scaliness* <input type="checkbox"/> Skin dimpling or retraction* <input type="checkbox"/> Previous normal CBE in the past 12 months – CBE not performed <input type="checkbox"/> CBE not performed, other or unknown reason <input type="checkbox"/> CBE refused 6. Was the CBE paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No *Requires diagnostic mammogram and further diagnostic evaluation.		7. Mammogram type: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic 8. Mammogram date: ____/____/____(mm/dd/yyyy) 9. What were the mammogram results? <input type="checkbox"/> Negative <input type="checkbox"/> Benign finding <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious abnormality <input type="checkbox"/> Highly suggestive of malignancy <input type="checkbox"/> Assessment is incomplete <input type="checkbox"/> Film comparison required <input type="checkbox"/> Unsatisfactory, film cannot be interpreted (Repeat Mamm.) <input type="checkbox"/> Result unknown, presumed abnormal, from non-program funded source 10. Was the mammogram paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Where was the mammogram performed? _____ 12. Are additional breast procedures needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not yet determined	
DIAGNOSTIC PROCEDURES			
13. Additional Mam Views: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral Procedure date ____/____/____(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Benign findings <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious abnormality <input type="checkbox"/> Highly suggestive of malignancy <input type="checkbox"/> Assessment incomplete <input type="checkbox"/> Refused (Complete Ref/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other		14. Ultrasound: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ____/____/____(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Normal (WNL) <input type="checkbox"/> Cystic mass <input type="checkbox"/> Other benign abnormality <input type="checkbox"/> Suspicious for malignancy <input type="checkbox"/> Refused (Complete Ref/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	
15. Film Comparison: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ____/____/____(mm/dd/yyyy) Procedure site: _____ Final Imaging Results: <input type="checkbox"/> Negative <input type="checkbox"/> Benign findings <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious abnormality <input type="checkbox"/> Highly suggestive of malignancy <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refused (Complete Ref/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other		16. Fine Needle/ Cyst Aspiration: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ____/____/____(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Not suspicious for cancer <input type="checkbox"/> Suspicious for cancer <input type="checkbox"/> No fluid/tissue collected <input type="checkbox"/> Refused (Complete Ref/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	
17. Biopsy/ Lumpectomy: <input type="checkbox"/> Yes <input type="checkbox"/> No Type of biopsy: <input type="checkbox"/> Excisional <input type="checkbox"/> Non Excisional Procedure date ____/____/____(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Normal breast tissue <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Other benign changes <input type="checkbox"/> DCIS <input type="checkbox"/> LCIS <input type="checkbox"/> Invasive cancer <input type="checkbox"/> Refused (Complete Ref/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other		18. Repeat CBE/ Surgical Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ____/____/____(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Normal (WNL) <input type="checkbox"/> Benign finding <input type="checkbox"/> Discrete palpable mass <input type="checkbox"/> Bloody or serous nipple discharge <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Skin dimpling or retraction <input type="checkbox"/> Refused (Complete Ref/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	
WORK-UP STATUS		TREATMENT STATUS	
19. What is the status of the final diagnosis? <input type="checkbox"/> Work-up complete <input type="checkbox"/> Client lost to follow-up (Complete Refused/LTFU Form) <input type="checkbox"/> Workup refused (Complete Refused/LTFU Form) <input type="checkbox"/> Irreconcilable		22. What is the status of breast cancer treatment? <input type="checkbox"/> Treatment started <input type="checkbox"/> Client lost to follow-up (Complete Refused/LTFU Form) <input type="checkbox"/> Treatment refused (Complete Refused/LTFU Form) <input type="checkbox"/> Treatment not recommended	
20. Date of final diagnosis: ____/____/____ (mm/dd/yyyy)		23. Date of treatment status: ____/____/____ (mm/dd/yyyy)	
21. Final Diagnosis: <input type="checkbox"/> Breast cancer not diagnosed <input type="checkbox"/> Invasive breast cancer <input type="checkbox"/> Ductal carcinoma in situ <input type="checkbox"/> Lobular carcinoma in situ <input type="checkbox"/> Reoccurrence of prior breast cancer		24. Was the client enrolled in Medicaid for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____ Form Completed by: _____	