



ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS)	REFERRING PROVIDER (FOR DIRECT BILLING)
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A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)				
DATE OF BIRTH MM / DD / YYYY	SOCIAL SECURITY NUMBER - - - - -	CLIENT ELIGIBILITY VERIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No		
INSURANCE COVERAGE <input type="checkbox"/> Yes <input type="checkbox"/> No	DEDUCTIBLE MET <input type="checkbox"/> Yes <input type="checkbox"/> No	REFERRAL FEE <input type="checkbox"/>	TYPE OF MEDICARE <input type="checkbox"/> Part A <input type="checkbox"/> Part A and B	BCCT <input type="checkbox"/> Yes <input type="checkbox"/> No

B. BREAST DIAGNOSTIC PROCEDURES Reporting only

Diagnostic Mammogram Conventional Digital Tomosynthesis MM / DD / YYYY

Additional Mammographic view(s)

Normal <input type="checkbox"/> L <input type="checkbox"/> R (1) Negative (Category 1) <input type="checkbox"/> (2) Benign Finding (Category 2)	Other <input type="checkbox"/> L <input type="checkbox"/> R (7) Unsatisfactory-not interpreted-repeat (not paid)
Abnormal <input type="checkbox"/> (3) Probably Benign (Category 3) <input type="checkbox"/> (4) Suspicious Abnormality (Category 4)	<input type="checkbox"/> (5) Highly Suggestive of Malignancy (Category 5) <input type="checkbox"/> (14) Additional Imaging Pending (Category 0)

Ultrasound MM / DD / YYYY Rescreen Reporting only

Left: <input type="checkbox"/> Complete <input type="checkbox"/> Limited Right: <input type="checkbox"/> Complete <input type="checkbox"/> Limited	<table style="width:100%;"> <tr> <td style="width:50%;"> Normal <input type="checkbox"/> L <input type="checkbox"/> R (1) Negative (Category 1) <input type="checkbox"/> (2) Benign Finding (Category 2) </td> <td style="width:50%;"> Abnormal <input type="checkbox"/> (3) Probably Benign (Category 3) <input type="checkbox"/> (4) Suspicious Abnormality (Category 4) - Refer to BCCT <input type="checkbox"/> (5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT </td> </tr> <tr> <td colspan="2"> Other <input type="checkbox"/> (7) Unsatisfactory - not interpreted - repeat (not paid) <input type="checkbox"/> (14) Needs Additional Evaluation (Category 0) </td> </tr> </table>	Normal <input type="checkbox"/> L <input type="checkbox"/> R (1) Negative (Category 1) <input type="checkbox"/> (2) Benign Finding (Category 2)	Abnormal <input type="checkbox"/> (3) Probably Benign (Category 3) <input type="checkbox"/> (4) Suspicious Abnormality (Category 4) - Refer to BCCT <input type="checkbox"/> (5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT	Other <input type="checkbox"/> (7) Unsatisfactory - not interpreted - repeat (not paid) <input type="checkbox"/> (14) Needs Additional Evaluation (Category 0)	
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Specialist Consultation Date MM / DD / YYYY Diagnostic Work-up Planned None 0-60 days 61-90 days Reporting only

CBE WNL Yes No (If "No" indicate finding below)

Benign finding (1) Fibrocystic changes, diffuse lumpiness, clearly defined thickening, or nodularity

Suspicious for cancer (2) Discrete palpable mass (3) Nipple discharge (4) Nipple or areolar scaliness or erythema
 (5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration; also one breast lower than usual; or unilateral prominent veins, or unilateral increase in size
 (6) Enlarged, tender, fixed, or hard palpable supraclavicular, infraclavicular, or axillary lymph nodes; also swelling of upper arm

Fine Needle/Cyst Aspiration MM / DD / YYYY Cytopathology Performed Yes No Reporting only

<p>Left Breast</p> <p>Type <input type="checkbox"/> Superficial <input type="checkbox"/> Deep tissue under guidance <input type="checkbox"/> First Lesion <input type="checkbox"/> Additional Lesion <input type="checkbox"/> Ultrasound <input type="checkbox"/> Ultrasound <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Cat Scan <input type="checkbox"/> Cat Scan <input type="checkbox"/> MRI <input type="checkbox"/> MRI</p> <p>Result <input type="checkbox"/> (1) Negative <input type="checkbox"/> (2) Indeterminate <input type="checkbox"/> (3) Suspicious for Malignancy - Refer to BCCT <input type="checkbox"/> (4) Malignancy - Refer to BCCT</p>	<p>Right Breast</p> <p>Type <input type="checkbox"/> Superficial <input type="checkbox"/> Deep tissue under guidance <input type="checkbox"/> First Lesion <input type="checkbox"/> Additional Lesion <input type="checkbox"/> Ultrasound <input type="checkbox"/> Ultrasound <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Cat Scan <input type="checkbox"/> Cat Scan <input type="checkbox"/> MRI <input type="checkbox"/> MRI</p> <p>Result <input type="checkbox"/> (1) Negative <input type="checkbox"/> (2) Indeterminate <input type="checkbox"/> (3) Suspicious for Malignancy - Refer to BCCT <input type="checkbox"/> (4) Malignancy - Refer to BCCT</p>
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Biopsy _____ / _____ / _____ Reporting only

Location Physician Office Hospital outpatient Facility Fee Yes No Anesthesia

Primary Biopsy Type: Clear

Breast Left Right Percutaneous

Stereotactic Guided (19081) Add Lesion Additional Primary Pathology:

US Guided (19083) No additional pathology

Needle Core, No Guidance (19100) 1 additional pathology

Incisional, No Guidance (19101) Mammogram Guided (19281) Stereotactic Guided (19283) US Guided (19285) 2 additional pathology

Excisional (19120 or 19125) Radiological exam of specimen? Yes No 3 additional pathology

Additional Lesion: Clear

Incisional, No Guidance (19101) Mammogram Guided Stereotactic Guided US Guided Additional Secondary Pathology:

Excisional (19120) Radiological exam of specimen? Yes No No additional pathology

1 additional pathology

2 additional pathology

3 additional pathology

Additional Facility Fee Yes No

Biopsy Result (Report only most severe result)

(1) Benign (1) Work-up Complete (Complete Section C)

(2) Benign/Atypical (2) Work-up Pending

(3) Indeterminate (3) Lost to Follow-up

(4) Malignancy (4) Work-up Refused (Describe in comment section/Must have signed waiver)

(9) Irreconcilable (Does not follow typical protocol - **FOR STAFF USE ONLY**)

_____ / _____ / _____
MM DD YYYY

Next Breast Cancer Screening Date _____ / _____ / _____ MM/ YYYY

Other Procedure (specify, note results in comments):

Ductogram Nipple Discharge Cytology (not reimbursed)

Skin Biopsy (not reimbursed) Magnetic Resonance Imaging (MRI) (not reimbursed)

Nuclear Scan (not reimbursed)

Other Procedure Date: _____ / _____ / _____
MM DD YYYY

C. BREAST DIAGNOSIS

Final Diagnosis

(3) Breast Cancer not diagnosed (5) Ductal Carcinoma In Situ (DCIS) (Stage 0)*

(4) Lobular Carcinoma In Situ (LCIS) (Stage 0)* (2) Invasive Breast Cancer*

Final Diagnosis/Imaging Date _____ / _____ / _____
MM DD YYYY

D. BREAST TREATMENT

Status of Treatment	Type
<input type="checkbox"/> (1) Started	<input type="checkbox"/> (1) Surgery
<input type="checkbox"/> (2) Pending	<input type="checkbox"/> (2) Radiation
<input type="checkbox"/> (3) Lost to F/U (Describe in comment section)	<input type="checkbox"/> (3) Chemotherapy
<input type="checkbox"/> (4) Refused (Describe in comment section/Must have signed waiver)	<input type="checkbox"/> (4) Hormone
<input type="checkbox"/> (5) Not Needed	<input type="checkbox"/> (5) Immunotherapy
	<input type="checkbox"/> (6) Other Cancer Therapy
	Specify _____

Treatment Facility
(Facility Name/City)

Date Treatment Started _____ / _____ / _____
MM DD YYYY

COMMENTS