MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)

BREAST DIAGNOSIS AND TREATMENT

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS)

REFERRING PROVIDER (FOR DIRECT BILLING)

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)

DATE OF BIRTH ____/____/_____ MM DD YYYY

SOCIAL SECURITY NUMBER _____ – _____ – _____

CLIENT ELIGIBILTY VERIFIED ☐ Yes ☐ No

INSURANCE COVERAGE ☐ Yes ☐ No

DEDUCTIBLE MET ☐ Yes ☐ No

REFERRAL FEE ☐

TYPE OF MEDICARE ☐ Part A ☐ Part A and B

BCCT ☐ Yes ☐ No

B. BREAST DIAGNOSTIC PROCEDURES

☐ **Reporting only**

Diagnostic Mammogram ☐ Conventional ☐ Digital ☐ Tomosynthesis _____/_____/_____ MM DD YYYY

Additional Mammographic view(s)

	L	R			L	R	
Normal	☐	☐	(1) Negative (Category 1)				
	☐	☐	(2) Benign Finding (Category 2)		☐	☐	(5) Highly Suggestive of Malignancy (Category 5)
Abnormal	☐	☐	(3) Probably Benign (Category 3)		☐	☐	(14) Additional Imaging Pending (Category 0)
	☐	☐	(4) Suspicious Abnormality (Category 4)	Other	☐	☐	(7) Unsatisfactory-not interpreted-repeat (not paid)

Ultrasound _____/_____/_____ MM DD YYYY ☐ Rescreen ☐ **Reporting only**

Left: ☐ Complete ☐ Limited

Right: ☐ Complete ☐ Limited

	L	R	
Normal	☐	☐	(1) Negative (Category 1)
	☐	☐	(2) Benign Finding (Category 2)
Abnormal	☐	☐	(3) Probably Benign (Category 3)
	☐	☐	(4) Suspicious Abnormality (Category 4) - Refer to BCCT
	☐	☐	(5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT
Other	☐	☐	(7) Unsatisfactory - not interpreted - repeat (not paid)
	☐	☐	(14) Needs Additional Evaluation (Category 0)

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**

Left Breast

Type ☐ Superficial
☐ Deep tissue under guidance
☐ First Lesion ☐ Additional Lesion
☐ Ultrasound ☐ Ultrasound
☐ Fluoroscopy ☐ Fluoroscopy
☐ Cat Scan ☐ Cat Scan
☐ MRI ☐ MRI

Result ☐ (1) Negative
☐ (2) Indeterminate
☐ (3) Suspicious for Malignancy - Refer to BCCT
☐ (4) Malignancy - Refer to BCCT

Right Breast

Type ☐ Superficial
☐ Deep tissue under guidance
☐ First Lesion ☐ Additional Lesion
☐ Ultrasound ☐ Ultrasound
☐ Fluoroscopy ☐ Fluoroscopy
☐ Cat Scan ☐ Cat Scan
☐ MRI ☐ MRI

Result ☐ (1) Negative
☐ (2) Indeterminate
☐ (3) Suspicious for Malignancy - Refer to BCCT
☐ (4) Malignancy - Refer to BCCT

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Biopsy ____/____/____ MM DD YYYY ☐ **Reporting only**

Location ☐ Physician Office ☐ Hospital outpatient Facility Fee ☐Yes ☐No Anesthesia ☐

Primary Biopsy Type: Clear

Breast ☐ **Left** ☐ **Right**

Percutaneous
☐ Stereotactic Guided (19081)
☐ U S Guided (19083)
☐ Needle Core, No Guidance (19100)
☐ Add Lesion

☐ Incisional, No Guidance (19101) ☐ Mammogram Guided (19281) ☐ Stereotactic Guided (19283) ☐ US Guided (19285)

☐ Excisional (19120 or 19125) Radiological exam of specimen? ☐ Yes ☐ No

Additional Primary Pathology:
☐ No additional pathology
☐ 1 additional pathology
☐ 2 additional pathology
☐ 3 additional pathology

Additional Lesion: Clear

☐ Incisional, No Guidance (19101) ☐ Mammogram Guided ☐ Stereotactic Guided ☐ US Guided

☐ Excisional (19120) ☐ Radiological exam of specimen? ☐ Yes ☐ No

☐ Immunohistochemistry (88342) ☐ Additional Immunohistochemistry (88341)

Additional Secondary Pathology:
☐ 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
☐ (2) Benign/Atypical
☐ (3) Indeterminate
☐ (4) Malignancy

Status of Final Diagnosis
☐ (1) Work-up Complete (Complete Section C)
☐ (2) Work-up Pending
☐ (3) Lost to Follow-up
☐ (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
☐ Skin Biopsy (not reimbursed)
☐ Nuclear Scan (not reimbursed)
☐ Nipple Discharge Cytology (not reimbursed)
☐ Magnetic Resonance Imaging (MRI) (not reimbursed)

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

C. BREAST DIAGNOSIS

Final Diagnosis
☐ (3) Breast Cancer not diagnosed
☐ (4) **Lobular Carcinoma In Situ (LCIS)** *(Stage 0)**
☐ (5) **Ductal Carcinoma In Situ (DCIS)** *(Stage 0)**
☐ (2) **Invasive Breast Cancer***

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

D. BREAST TREATMENT

Status of Treatment
☐ (1) Started
☐ (2) Pending
☐ (3) Lost to F/U (Describe in comment section)
☐ (4) Refused (Describe in comment section/Must have signed waiver)
☐ (5) Not Needed

Type
☐ (1) Surgery
☐ (2) Radiation
☐ (3) Chemotherapy
☐ (4) Hormone
☐ (5) Immunotherapy
☐ (6) Other Cancer Therapy
Specify _____

Treatment Facility
(Facility Name/City)

Date Treatment Started MM / DD / YYYY

COMMENTS

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