# WV Breast and Cervical Cancer Screening Program
# Breast Diagnostic Report

Referral Facility: _____ Phone: ( ___ ) _____ _____

CBE Date (mm/dd/yyyy): ____/____/____ Mammogram Date(mm/dd/yyyy): ____/____/____

Client Name (Last, First, MI):

Social Security Number: ____/____/____ Date of Birth: ____/____/____

## BREAST PROCEDURES & RESULTS (Dates in mm/dd/yyyy)

**☐ Surgical Consultation**

Date Performed: ____/____/____

☐ Biopsy/FNA Recommended
☐ No Intervention—Routine FU
☐ Not Done-Other/Unk Reason
☐ Refused
☐ Short Term FU in Six (6) Months
☐ Surgery or Tx Recommended
☐ Ultrasound Recommended
☐ Unknown

**Paid by WVBCCSP?** ☐ Yes ☐ No

**☐ Consultant Repeat CBE**

Date Performed: ____/____/____

☐ Benign Finding
☐ Bloody/Serious Nipple Discharge
☐ Discrete Palpable Mass (Dx Benign)
☐ Discrete Palpable Mass-Susp for Cancer
☐ Nipple/Areolar Scaliness
☐ Normal Exam
☐ Not Done-Other/Unk Reason
☐ Refused
☐ Skin Dimpling/Retraction
☐ Unknown

**Paid by WVBCCSP?** ☐ Yes ☐ No

**☐ Biopsy**

Date Performed: ____/____/____

☐ Atypical Ductal Hyperplasia (ADH)
☐ Ductal Carcinoma In Situ (DCIS)
☐ Hyperplasia
☐ Invasive Breast Cancer
☐ Lobular Carcinoma In Situ
☐ Normal Breast Tissue
☐ Not Done-Other/Unk Reason
☐ Other Benign Changes
☐ Refused
☐ Unknown

**Paid by WVBCCSP?** ☐ Yes ☐ No

**☐ Fine Needle Aspirate (FNA)**

Date Performed: ____/____/____

☐ No Fluid/Tissue Obtained
☐ Not Done—Other/Unk Reason
☐ Not Suspicious for Cancer
☐ Refused
☐ Suspicious for Cancer
☐ Unknown

**Paid by WVBCCSP?** ☐ Yes ☐ No

## BREAST RECOMMENDATION

Date Patient Notified(mm/dd/yyyy): ____/____/____

☐ Additional Mam Views
☐ Biopsy
☐ CBE by Consult
☐ Fine Needle Aspirate (FNA)
☐ Follow Routine Screening
☐ MRI: *WVBCCSP does NOT reimburse for MRI*
☐ Obtain Definitive Rx
☐ Repeat Mammogram Immediately
☐ Short Term Follow-up Mam in Six (6) Months
☐ Surgical Consult
☐ Ultrasound: *Reimbursement only when performed within one month of mammogram.*

## CYCLE DISPOSITION FOR DIAGNOSTIC PROCEDURES / STATUS OF FINAL DIAGNOSIS

Date(mm/dd/yyyy): ____/____/____

☐ Complete ☐ Deceased ☐ Lost to Follow-up ☐ Refused

### FINAL DIAGNOSIS

Date(mm/dd/yyyy): ____/____/____

☐ Breast Cancer Not Diagnosed

☐ Ductal Carcinoma In Situ (DCIS) - Stage 0
☐ Invasive Breast Cancer*
☐ Lobular Carcinoma In Situ (LCIS) - Stage 0*

*Treatment status and treatment date required for these diagnoses.

### TREATMENT STATUS

Date(mm/dd/yyyy): ____/____/____

☐ Client Deceased
☐ Not Indicated/Not Needed
☐ Transportation Problems
☐ Financial Problems
☐ Pending/Unknown
☐ Treatment Started
☐ Lost to Follow-up
☐ Refused by Client
☐ Other Problems: _____

## NOTES/GENERAL COMMENTS

Original: WVBCCSP Two (2) copies: Provider OMCFH/WVBCCSP Form #Y407 Rev. 06/23

Send to: WVBCCSP 350 Capitol Street, Room 427, Charleston, WV 25301-3714