

**ARKANSAS DEPARTMENT OF HEALTH
BREASTCARE SCREENING FORM**

MM/DD/YYYY – Date of Exam		Patient's BreastCare ID Number 7777	
Last Name of Patient		First Name of Patient	MI
Date of Birth	Social Security Number:	Smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes If smoker, <input type="checkbox"/> Referred to Tobacco Quitline <input type="checkbox"/> Refused referral to Quitline or referral not needed	
Name of Clinic		County of Clinic	
<p>Does the client report any of the following breast symptoms?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Check all that apply) <input type="checkbox"/> Palpable mass <input type="checkbox"/> Skin ulceration/inflammation <input type="checkbox"/> Skin dimpling <input type="checkbox"/> Spontaneous nipple discharge <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Focal pain <input type="checkbox"/> Other _____ <p><i>(If yes, refer for diagnostic mammogram)</i></p>		<p>Does the client report any of the following cervical symptoms?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Check all that apply) <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Post menopausal bleeding <input type="checkbox"/> Irregular bleeding <p><i>(If yes, refer for GYN consult regardless of Pap test results)</i></p>	
<p>Clinical Breast Exam (Objective Findings):</p> <input type="checkbox"/> Normal/benign (includes scarring And implants) <input type="checkbox"/> Abnormal (Check abnormality) <input type="checkbox"/> Palpable mass/thickening (refer for US & diagnostic mammogram) <input type="checkbox"/> Skin dimpling/retraction/ inflammation <input type="checkbox"/> Spontaneous nipple discharge observed <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Needed, but not performed (includes refused) <input type="checkbox"/> Not done <p><i>For abnormal CBE, refer for diagnostic mammogram, follow-up required</i></p>		<p>Pap Test: (Check type of Pap Performed) <input type="checkbox"/> Liquid-based with ASC-US Reflex Testing <input type="checkbox"/> Conventional smear</p> <p>Pap not needed because: <input type="checkbox"/> Benign hyst, no cervix <input type="checkbox"/> Pap test in past 12-24 months Date of last Pap _____ <input type="checkbox"/> Negative LBT last year <input type="checkbox"/> 3 Negative/benign consecutive Pap tests in last 5 yrs <input type="checkbox"/> Pap needed, but not performed (includes refused)</p> <p>Note: ASC-US reflex testing for HPV High Risk DNA must be ordered for all liquid-based tests (LBT). HPV High Risk DNA Testing is reimbursable for laboratories.</p>	
<p>Pelvic Exam:</p> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, not suspicious for cancer <input type="checkbox"/> Abnormal, suspicious for cancer <input type="checkbox"/> Not done			
Print Name and Title of Person Performing Pap and/or CBE		Name of Cytology Laboratory for Paps	
Mammogram Appointment Date	Appointment Time	Check scheduled procedure(s): <input type="checkbox"/> Screening Mammogram (film or digital) <input type="checkbox"/> Diagnostic Mammogram (film or digital) <input type="checkbox"/> Ultrasound	
Name of Mammogram Facility		Town of Facility	

Fax Completed Form to 501-661-2264.