

## Instructions for Breast Diagnostic Form (front of diagnostic form)

### Purpose

To document the notification, follow-up and treatment dates of patients with abnormal mammogram and/or CBE results.

### Used by

Community Health Centers, (CHCs), and Area Health Education Centers, (AHECs)

### Explanations and definitions

Field	Directions
BreastCare #7777	Enter BreastCare number from the patient's BreastCare card that begins with four sevens.
Diagnostic Referral	Check Yes if patient is referred to the LHU for diagnostic evaluation following an abnormal mammogram before enrolling into BreastCare.
Date to Central Office	Enter date(s) this form is faxed to Central Office.
Name of Patient	Self-explanatory.
Birth Date	Self-explanatory.
Social Security Number	Self-explanatory. Enter N/A if patient has no SSN.
Name of Clinic	Enter name of clinic, not an individual's name.
Clinic Phone Number	Enter clinic's phone number, including area code.
Contact Nurse	BreastCare Case Manager/designee who completes this form.
INITIATE FORM FOR THESE ABNORMAL RESULTS and REFER TO CARE COORDINATOR:	Check appropriate box/boxes for all initial abnormal results and enter dates. If Abnormal CBE is checked and mammogram is neg, check next appropriate procedure. (This form is not completed for probably benign result.)
Additional Imaging Procedures: Film Comparison, Diagnostic Mammogram, and Ultrasound	Check the appropriate box/boxes indicating the type and result of each additional imaging procedure. Enter the appointment date, location, and date procedure/visit is done. If patient misses first appointment, circle date, reschedule appointment, and enter date in second space. If the procedure is not done, check not done. If a film comparison, diagnostic mammogram after a screening mammogram, and/or ultrasound is done, final imaging outcome and date must be completed.  NOTE: Enter information only for procedures listed. Do not write in additional procedures or other information.  <b>Film comparison is only used when required to further evaluate an initial mammogram result of Assessment Incomplete.</b>

Field	Directions
<p>Date of Final Imaging Outcome: Final Imaging Outcome:</p>	<p>This is the assessment from all imaging procedures, including comparison with previous films, needed to arrive at a final outcome. Check the appropriate box for final imaging outcome if film comparison, diagnostic mammogram after a screening mammogram, and/or ultrasound is done. Enter the date of Final Imaging Outcome. If at least one procedure was planned, but patient refused or was Lost to follow-up before its completion, indicate this under "Reason for Closing". If additional imaging is performed on more than one date, report the date of the last procedure used to determine the final imaging outcome.</p>
<p>MD Consult, Biopsy and Fine Needle Cyst Aspiration</p>	<p>Check the appropriate box/boxes indicating the type and result of each procedure/visit the patient receives. The type of biopsy must be checked. Enter the appointment date, physician's name, and date procedure/visit is done. If patient misses first appointment, circle date, reschedule appointment, and enter date in second space. If the procedure is not needed, circle Date Done to indicate procedure not done.</p> <p>NOTE: Enter information only for procedures listed. Do not write in additional procedures or other information.</p>
<p>FINAL DIAGNOSIS</p>	<p>Must check appropriate box indicating breast cancer not diagnosed or type of cancer, if one or more procedures/consultation above have been done. Enter date of final diagnosis. Check appropriate box indicating when the next mammogram/ultrasound/MD consultation is due after a final diagnosis has been reached. If date of next recommended mammogram is less than one year, enter number of months. Check appropriate box and enter date.</p> <p><b>Refer to Care Coordinator if breast cancer diagnosed.</b></p>
<p>Date of Closure/Reason For Closing</p>	<p>Check appropriate box and enter date. If patient is lost to follow up or refuses, check appropriate box indicating reason. If Other is checked, specify, e.g., husband forbids, no access to provider, no transportation, religion.</p> <p>NOTE: Check Declines ADH Services box if the patient is not returning for follow-up/annual mammograms.</p>
<p>COMPLETE ONLY IF CANCER IS DIAGNOSED</p>	<p>Check appropriate box for Stage at Diagnosis. Enter tumor size. If treatment is indicated, enter date first treatment was started and check type of treatment. If treatment is not indicated, check appropriate box. Check appropriate box(s) for all additional types of treatment the patient receives. Treatment information can be obtained from biopsy/surgeon/pathology reports or the Cancer Registry.</p> <p><b>*This box is completed by Regional Care</b></p>

Field	Directions
	<b>Coordinator if client referred per case management policy.</b>

***Mechanics and filing***

Initiate and place loosely in the patient's record a Breast Diagnostic Form each time there is an abnormal CBE or mammogram. Use the Breast Diagnostic Form to track a patient until follow-up is complete.

When the first entry is made in the abnormal results section and when follow-up is completed, fax an updated copy to BreastCare at 501-661-2264.

**\*Refer to Regional Care Coordinator for:**

Birads 4 Mammogram - Suspicious, recommend biopsy or surgical consult

Birads 5 Mammogram - Highly Suspicious for Malignancy

Ultrasound - Solid mass/suspicious for cancer

Abnormal CBE requiring biopsy

Breast Cancer

BreastCare # 7777 _____	ARKANSAS DEPARTMENT OF HEALTH	Date to Central Office
<b>Diagnostic Referral</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	BreastCare – Slot 11 Breast Diagnostic Form FAX TO: 501-661-2264	Date to Central Office

Name of Patient   Last	First	MI	Birth Date	Social Security Number
Name of Clinic		Clinic Phone Number		Contact Nurse

**INITIATE FORM FOR THESE ABNORMAL RESULTS and REFER TO CARE COORDINATOR:**

<input type="checkbox"/> Abnormal CBE (Follow-Up Indicated)  Date: _____  <b>Fax form to Central Office</b>	<input type="checkbox"/> Abnormal Screening Mammogram (Check One) Date _____ <input type="checkbox"/> Assessment Incomplete – Need additional imaging <input type="checkbox"/> Film Comparison Required <input type="checkbox"/> Suspicious Abnormality <input type="checkbox"/> Highly Suggestive of Malignancy	<input type="checkbox"/> Abnormal Diagnostic Mammogram (Check one)  Date _____ <input type="checkbox"/> Assessment Incomplete <input type="checkbox"/> Assessment Incomplete- Film Comparison Required <input type="checkbox"/> Suspicious Abnormality <input type="checkbox"/> Highly Suggestive of Malignancy
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**ADDITIONAL IMAGING PROCEDURES:**

<input type="checkbox"/> Film Comparison <input type="checkbox"/> Date Done _____ <input type="checkbox"/> Not Done	<input type="checkbox"/> Diagnostic Mammogram (for additional imaging) Appt. date 1) _____ 2) _____ Facility _____ Date Done _____	<input type="checkbox"/> Negative <input type="checkbox"/> Benign <input type="checkbox"/> Probably Benign <input type="checkbox"/> Suspicious for Malignancy <input type="checkbox"/> Highly Suggestive of Malignancy
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<input type="checkbox"/> Ultrasound    Appt. date 1) _____ 2) _____  Location _____  Date Done _____	<input type="checkbox"/> Normal/No Abnormality <input type="checkbox"/> Benign Abnormality <input type="checkbox"/> Cystic Mass / Simple cyst <input type="checkbox"/> Solid Mass / Complex cyst (suspicious for CA)
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**Date of Final Imaging Outcome:** \_\_\_\_\_  
**Final Imaging Outcome:**  
 Negative    Benign    Probably Benign    Suspicious Abnormality    Highly Suggestive of Malignancy    Unsatisfactory

<input type="checkbox"/> MD Consultation    Appt. date 1) _____ 2) _____ Physician _____ Date Done _____	<input type="checkbox"/> No Intervention <input type="checkbox"/> Short Term Follow-up in ____ months <input type="checkbox"/> Biopsy/FNA Recommended
<input type="checkbox"/> Biopsy: <input type="checkbox"/> Core    Appt. date 1) _____ 2) _____ <input type="checkbox"/> Stereotactic    Physician _____ <input type="checkbox"/> Excisional    Date Done _____	<input type="checkbox"/> Hyperplasia <input type="checkbox"/> Other Benign Changes <input type="checkbox"/> Ductal CA in Situ <input type="checkbox"/> Lobular CA in Situ <input type="checkbox"/> Cancer, Invasive
<input type="checkbox"/> Fine Needle Cyst Aspiration    Appt. date 1) _____ 2) _____ Physician _____ Date Done _____	<input type="checkbox"/> No Fluid or Tissue <input type="checkbox"/> Non-Suspicious <input type="checkbox"/> Suspicious for Neoplasm

**FINAL DIAGNOSIS:** (Must complete if one or more procedures/consultations above have been done)

Date _____ (Should be 60 days or less from date of first abnormal result)	<input type="checkbox"/> Breast Cancer Not Diagnosed <input type="checkbox"/> Ductal CA in Situ (DCIS) <input type="checkbox"/> Lobular CA in Situ (LCIS) <input type="checkbox"/> Cancer, Invasive	Follow-up Recommendation: <input type="checkbox"/> Next Mammogram 1 yr <input type="checkbox"/> Next Mammogram and/or Ultrasound in ____ months <input type="checkbox"/> Next MD visit _____ months
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**DATE OF CLOSURE** \_\_\_\_\_    **REASON FOR CLOSING:**

<input type="checkbox"/> Follow-up complete  <b>Fax form to Central Office</b>	Patient Refused (check one and <b>refer to CC</b> ) <input type="checkbox"/> no symptoms <input type="checkbox"/> fear <input type="checkbox"/> illness/injury <input type="checkbox"/> too busy <input type="checkbox"/> other _____	Lost to Follow-up (check one and <b>refer to CC</b> ) <input type="checkbox"/> Moved <input type="checkbox"/> DNKA <input type="checkbox"/> Unable to Locate <input type="checkbox"/> Deceased <input type="checkbox"/> Declines ADH Services
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<p><b>COMPLETE ONLY IF CANCER IS DIAGNOSED</b></p> <input type="checkbox"/> Stage 0    No tumor size (DCIS, LCIS) <input type="checkbox"/> Stage I    AJCC <input type="checkbox"/> Stage III    AJCC <input type="checkbox"/> Stage II    AJCC <input type="checkbox"/> Stage IV    AJCC  Tumor Size _____ CM	Date Treatment Started _____ <input type="checkbox"/> Treatment Not Indicated <input type="checkbox"/> Lumpectomy/partial mastectomy    Date _____ <input type="checkbox"/> Mastectomy    Date _____ <input type="checkbox"/> Sentinel Node Biopsy    Date _____ <input type="checkbox"/> Radiation    Date _____ <input type="checkbox"/> Chemotherapy    Date _____ <input type="checkbox"/> Hormone Therapy    Date _____
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