Washington State Department of Health
DOH 345-211 June 2018

Public Health
Seattle & King County

Breast Cervical & Colon Health Program
401 5th Ave #1110 Seattle WA 98104
T 206-263-8176 F 206-296-0208

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

Breast Diagnostic Form

BCCHP ID#: **Authorization #:**

CLIENT NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF PROCEDURE
REFERRING PROVIDER/CLINIC SITE	SPECIALTY CLINIC SITE	PLACE OF SERVICE ☐ Office ☐ Hospital ☐ ASC	CHART NUMBER
Referred for diagnostic evaluation by non-BCCHP provider on date:	SPECIALTY PROVIDER NAME		

☐ **Surgical Consult / Repeat Clinical Breast Exam** CBE Result: ☐ Normal ☐ Abnormal - Findings
Recommendation:

Procedures & Results

Which Breast:	☐ Left ☐ Right
☐ **Ultrasound**	☐ Neg ☐ Benign ☐ Probably Benign ☐ Suspicious Abnormality ☐ Highly Suggest Malig ☐ Assess Incomplete ☐ Tech Unsatisfactory
☐ **Breast Smear**	☐ Neg Malig ☐ Pos Malig ☐ Indeterm/ Atyp ☐ Non-Diag / Needs rpt ☐ No Specimen
☐ **Biopsy**	☐ Neg Malig ☐ Pos Malig ☐ Indeterm/ Atyp ☐ Non-Diag / Needs rpt ☐ No Specimen
Type of Biopsy:	☐ Percutaneous ☐ Open ☐ Skin
Type of Localization Guidance:	☐ Mammogram ☐ Ultrasound ☐ MRI
☐ **FNA**	☐ Neg Malig ☐ Pos Malig ☐ Indeterm/ Atyp ☐ Non-Diag / Needs rpt ☐ No Specimen
Imaging:	☐ Yes ☐ No
☐ **Cyst Aspiration**	☐ Neg Malig ☐ Pos Malig ☐ Indeterm/ Atyp ☐ Non-Diag / Needs rpt ☐ No Specimen
☐ **Ducto/Galactogram**	☐ Neg Malig ☐ Pos Malig ☐ Indeterm/ Atyp ☐ Non-Diag / Needs rpt ☐ No Specimen

Final Dx/Status

☐ Not Cancer ☐ Lobular Carcinoma In Situ* ☐ Ductal Carcinoma In Situ* ☐ Cancer Invasive* ☐ Atypical Hyperplasia*

If diagnosed with these diagnoses, contact BCCHP to enroll in the Breast and Cervical Cancer Treatment Program (BCCTP)

☐ Work-up complete – Date: Recommended follow-up:
☐ Work-up pending – Date: Why Pending:
☐ **Lost to follow-up – Date: Why Lost:
☐ **Work-up refused – Date: Why Refused:

***** Provide documentation to BCCHP Prime Contractor of attempts to contact client***

Treatment recommended: Date:	☐ Axillary Dissection	☐ Sentinel Node Biopsy	☐ Lumpectomy
Mastectomy : ☐ Radical ☐ Modified	☐ Chemotherapy	☐ Radiation	☐ Endocrine Therapy

If referred for treatment, treatment clinical site/provider:

DIAGNOSTIC PROVIDER SIGNATURE	Print Name	Telephone Number	Date

PLEASE FAX FORM TO BCCHP: (206) 263-296-0208

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY call 711)