Washington State Department of Health
DOH 140-174 Jan 2018

Public Health
Seattle & King County

Breast Cervical & Colon Health Program
Public Health Seattle & King County
T 206-263-8309 F 206-296-0208

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

Breast Cancer Treatment Program Tracking Form

Client Last Name	Client First Name	MI	Social Security Number:	Date of Birth:

BCCHP Prime Contractor: SEAT	BCCHP ID #	Provider One #
Primary Care Provider Name:	Enrolling Clinic Name :	Clinic Chart #:

Breast Diagnosis Date: _____

1. ☐ **Unspecified Benign Dysplasia* -** Dx code:**N60.99**
   (* Unspecified Benign Dysplasia is not a qualifying diagnosis *for AEM/ERSO)*
2. ☐ **Carcinoma in situ (CIS) of breast – Right Side (Choose one from the options below)**
   - ☐ **Lobular CIS, right -** Dx code: **D05.01**
   - ☐ **Intraductal CIS, right -** Dx code: **D05.11**
   - ☐ **Other CIS, Specified right -** Dx code: **D05.81**
   - ☐ **Other CIS, Unspecified right -** Dx code:**D05.91**
3. ☐ **Carcinoma in situ (CIS) of breast – Left Side (Choose one from the options below)**
   - ☐ **Lobular CIS, left -** Dx code: **D05.02**
   - ☐ **Intraductal CIS, left-** Dx code: **D05.12**
   - ☐ **Other CIS, Specified left -** Dx code: **D05.82**
   - ☐ **Other CIS, Unspecified left-** Dx code: **D05.92**
4. ☐ **Malignant Neoplasm – Right Side -** Dx code: **C50.911**
5. ☐ **Malignant Neoplasm – Left Side -** Dx code: **C50.912**
6. ☐ **Metastatic disease** **Site of Metastatic Disease**_____

Current Treatment Plan - Breast

☐ **Office Visit to initiate staging and treatment plan Appointment Date:**_____
☐ **Chemotherapy Start Date:**_____ **End Date:**_____
☐ **Radiation Start Date:**_____ **End Date:** _____
☐ **Surgery:** ☐ **Excision** ☐ **Lumpectomy Date of Surgery:**_____
☐ **Surgery: Mastectomy:** ☐ **Modified** ☐ **Radical Date of Surgery:** _____
☐ **Surgery: Reconstruction* Date of Surgery:** _____ *(* reconstruction not available for AEM/ERSO)*
☐ **Endocrine therapy: Prescription Name :** _____
Start date of Endocrine therapy: _____ **Proposed end date:** _____

Treatment Status: ☐ **Active** ☐ **Complete** ☐ **Declines/refuses** ☐ **Lost to follow-up**

Treatment end date: _____

Treatment Comments / Follow-up Plan:

Provider (signature): _____ **Date:** _____ **NPI #** _____

Provider Name (print): _____ **Phone:** _____ **Fax #**_____

FOR BCCHP CASE MANAGER USE:

☐ **AEM/ERSO eligible only**
☐ **New enrollment**
☐ **Renewal – client continues active treatment**
☐ **Other:** _____

BCCHP Case Manager:
Email:
Phone: 206-263-8309 **Fax:206-296-0208**

☐ **No longer eligible for BCCTP (S30):**
- ☐ **All cancer treatment completed**
- ☐ **Now eligible for Apple Health**
- ☐ **Now eligible for Medicare**
- ☐ **Has other Creditable Insurance**
- ☐ **Moving out of state to:**_____
- ☐ **Renewal forms not completed**

Case Manager Signature: _____ **Date:** _____