West Virginia 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. 06/22

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