



WOMEN'S WAY BREAST DIAGNOSTIC RESULTS

NORTH DAKOTA DEPARTMENT OF HEALTH

COMMUNITY AND HEALTH SYSTEMS

SFN 51772 (3-2020)

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For LCU Use Only

Navigation Only

Yes No

Client Name (Last, First)	Date of Birth	Alternate ID Number
Facility Name	Provider Name	Appointment Date

Consultant / Repeat Breast Exam

Result: <input type="checkbox"/> Normal <input type="checkbox"/> Benign Finding <input type="checkbox"/> Bloody /serous nipple discharge* <input type="checkbox"/> Discrete Palp mass - (Dx Benign) <input type="checkbox"/> Nipple/areolar scaliness* <input type="checkbox"/> Discrete Palp mass - Susp for Cancer* <input type="checkbox"/> Skin dimpling /retraction* <input type="checkbox"/> Refused <input type="checkbox"/> Not done-other/unknown reason	Date Repeat CBE Performed	Date Client Notified
Repeat CBE Paid by <i>Women's Way</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Recommended Follow-Up:

<input type="checkbox"/> Follow Routine Screening Schedule	<input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____
<input type="checkbox"/> Additional Mammographic Views	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI

Additional Views/Diagnostic Mammogram **Film Comparison**

Results <input type="checkbox"/> BI-RADS 1 Negative Finding <input type="checkbox"/> BI-RADS 2 Benign Finding <input type="checkbox"/> BI-RADS 3 Probably Benign (Consider Short Term Follow-up) <input type="checkbox"/> BI-RADS 4 Suspicious Abnormality (Biopsy should be Considered)* <input type="checkbox"/> BI-RADS 5 Highly Suggestive of Malignancy (Take Appropriate Action)* <input type="checkbox"/> BI-RADS 6 Known Biopsy - Proven Malignancy* <input type="checkbox"/> BI-RADS 0 Assessment Incomplete (Need Additional Imaging)* <input type="checkbox"/> Result Unknown - Presumed Abnormal* <input type="checkbox"/> Unsatisfactory Film <input type="checkbox"/> Result Pending <input type="checkbox"/> Film Comparison Required	Date Mammogram or Film Comparison Performed Date Client Notified of Result Dx Mammogram Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No Film Comparison Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

<input type="checkbox"/> Follow Routine Screening Schedule	<input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____
<input type="checkbox"/> Additional Mammographic Views	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI

Ultrasound **MRI**

Results <input type="checkbox"/> BI-RADS 1 <input type="checkbox"/> BI-RADS 2 <input type="checkbox"/> BI-RADS 3 <input type="checkbox"/> BI-RADS 4 <input type="checkbox"/> BI-RADS 5 <input type="checkbox"/> BI-RADS 0 <input type="checkbox"/> BI-RADS 6 <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date Ultrasound Performed	Results <input type="checkbox"/> BI-RADS 1 <input type="checkbox"/> BI-RADS 2 <input type="checkbox"/> BI-RADS 3 <input type="checkbox"/> BI-RADS 4 <input type="checkbox"/> BI-RADS 5 <input type="checkbox"/> BI-RADS 0 <input type="checkbox"/> BI-RADS 6 <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date MRI Performed
Date Client Notified of Result		Date Client Notified of Result	
US Paid by <i>Women's Way</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No		MRI Paid by <i>Women's Way</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Recommended Follow-Up: <input type="checkbox"/> CBE by Consult <input type="checkbox"/> Surgical Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> Additional Imaging _____ <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Follow Routine Screening Schedule <input type="checkbox"/> Short-Term Follow-up _____ Number of Months: _____	Recommended Follow-Up: <input type="checkbox"/> CBE by Consult <input type="checkbox"/> Surgical Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> Additional Imaging _____ <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Follow Routine Screening Schedule <input type="checkbox"/> Short-Term Follow-up _____ Number of Months: _____
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Surgical Consultation

Results <input type="checkbox"/> No Intervention, Routine Follow-Up <input type="checkbox"/> Short-Term Follow-Up <input type="checkbox"/> Biopsy/FNA Recommended <input type="checkbox"/> Refused <input type="checkbox"/> Ultrasound Recommended <input type="checkbox"/> Surgery or Treatment Recommended <input type="checkbox"/> Not done--other/unknown reason	Date Consult Performed Date Client Notified of Result Consult Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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* Additional diagnostic tests required

(Surgical Consultation continued on next page)

Client Name (Last, First)	Date of Birth
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Surgical Consultation Recommended Follow-Up:

<input type="checkbox"/> Follow Routine Screening Schedule	<input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____
<input type="checkbox"/> Additional Mammographic Views	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI

Fine Needle Aspiration

Results <input type="checkbox"/> Inadequate Sample of Fluid or Tissue <input type="checkbox"/> Not Suspicious for Cancer / Benign Carcinoma <input type="checkbox"/> Suspicious for Cancer <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date FNA Performed Date Client Notified of Result FNA Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

<input type="checkbox"/> Follow Routine Screening Schedule	<input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____
<input type="checkbox"/> Additional Mammographic Views	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI

Biopsy

Results <input type="checkbox"/> Normal Breast Tissue <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Other Benign Changes <input type="checkbox"/> Atypical Ductal Hyperplasia (ADH) <input type="checkbox"/> Invasive Breast Cancer <input type="checkbox"/> Lobular CIS <input type="checkbox"/> Ductal CIS <input type="checkbox"/> CIS - Other <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date Biopsy Performed Date Client Notified of Result Biopsy Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

<input type="checkbox"/> Follow Routine Screening Schedule	<input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____
<input type="checkbox"/> Additional Mammographic Views	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI

FINAL DIAGNOSIS RESULTS

<input type="checkbox"/> Cancer Not Diagnosed <input type="checkbox"/> Cancer Diagnosed* <input type="checkbox"/> Refused <input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> Irreconcilable/Incomplete <input type="checkbox"/> Other (specify): _____	Date of Final Diagnosis
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If cancer diagnosed, complete the following:

Cancer Stage

Ductal Carcinoma in Situ (DCIS) - Stage 0* Lobular Carcinoma in Situ (LCIS) - Stage 0* Invasive Breast Cancer*

Tumor Stage

Stage I Stage II Stage III Stage IV Stage Unknown Unstaged
 Summary Local Summary Regional Summary Distant

Tumor Size in CM (use decimal format and largest measurement; example: 1x2.4 = 2.4 cm)

BREAST CANCER TREATMENT STATUS

Treatment Status Date (date treatment plan developed and started)	Treatment Status <input type="checkbox"/> Started <input type="checkbox"/> Pending/Unknown <input type="checkbox"/> Refused <input type="checkbox"/> Lost to Follow-Up
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If treatment started, complete the following:

Treatment Provided	Date Provided	Treatment Provided	Date Provided
<input type="checkbox"/> Lumpectomy		<input type="checkbox"/> Radiation	
<input type="checkbox"/> Modified Mastectomy		<input type="checkbox"/> Chemotherapy	
<input type="checkbox"/> Modified Radical Mastectomy		<input type="checkbox"/> Other:	

Treatment Provided By

* Additional diagnostic tests required