



# BREAST DIAGNOSTIC AND FOLLOW-UP FORM

## ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (ABCCEDP)

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Tracking Number (required)

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| Name: _____<br><small>(Last) (First) (Middle)</small>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Date of Birth: ____ / ____ / ____<br><small>(mm) (dd) (yyyy)</small> |  |
| Social Security Number: XXX - XX -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | Referring Clinic Provider: _____                                     |  |
| Physician/Surgeon: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Phone No: _____ Appointment Date: ____ / ____ / ____                 |  |
| Reason for Referral: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Mammogram/US Result _____ Date Performed: ____ / ____ / ____         |  |
| Insurance Status: <input type="checkbox"/> No Insurance <input type="checkbox"/> Underinsurance <input type="checkbox"/> Insured                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Billed to Medicaid: _____ Yes                                        |  |
| <input type="checkbox"/> Repeat CBE/Surgical consultation:<br>Result: <input type="checkbox"/> Refused/Not done Date Performed: ____ / ____ / ____<br><input type="checkbox"/> No intervention/routine follow-up Provider: _____<br><input type="checkbox"/> Short term follow-up: ____ mos.<br><input type="checkbox"/> Biopsy/FNA recommended                                                                                                                                                                                                                                                                                                                                                |  |                                                                      |  |
| <input type="checkbox"/> Fine Needle Aspiration/Cyst Aspiration<br>Result: <input type="checkbox"/> Refused/Not done Date Performed: ____ / ____ / ____<br><input type="checkbox"/> No fluid or tissue obtained Provider: _____<br><input type="checkbox"/> Non-suspicious<br><input type="checkbox"/> Suspicious for neoplasm                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                      |  |
| <input type="checkbox"/> Biopsy Result: <input type="checkbox"/> Refused/Not done<br><input type="checkbox"/> Surgical <input type="checkbox"/> Hyperplasia<br><input type="checkbox"/> Stereotactic <input type="checkbox"/> Other benign changes<br><input type="checkbox"/> Core Needle <input type="checkbox"/> Lobular Carcinoma In Situ (LCIS)* Date Performed: ____ / ____ / ____<br>*Please contact your Area Screening Coordinator as soon as diagnosis of cancer is known. <input type="checkbox"/> Carcinoma in situ* Provider: _____<br><input type="checkbox"/> Invasive breast cancer*<br><input type="checkbox"/> Normal breast tissue<br><input type="checkbox"/> Other: _____ |  |                                                                      |  |
| <input type="checkbox"/> Other Tests Performed<br>If yes, specify: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Date Performed: ____ / ____ / ____<br>Provider: _____                |  |
| Final Diagnosis<br><input type="checkbox"/> Breast Cancer not diagnosed<br><input type="checkbox"/> Ductal Carcinoma In Situ (DCIS) Date Performed: ____ / ____ / ____<br><input type="checkbox"/> Lobular Carcinoma In Situ (LCIS)<br><input type="checkbox"/> Invasive Breast Cancer                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                      |  |
| Status of Diagnostic Work-up<br><input type="checkbox"/> Work-up completed <input type="checkbox"/> Work-up pending<br><input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Irreconcilable*<br><input type="checkbox"/> Work-up refused                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Date Performed: ____ / ____ / ____                                   |  |
| * If the provider refers for short-term follow-up instead of following guidelines.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                      |  |
| Treatment Status<br><input type="checkbox"/> Initiated <input type="checkbox"/> Refused<br><input type="checkbox"/> Pending <input type="checkbox"/> Not indicated<br><input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Updated (follow-up information)                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                      |  |
| Treatment (not paid by Alabama Breast and Cervical Cancer Program)<br><input type="checkbox"/> Mastectomy<br><input type="checkbox"/> Lumpectomy<br><input type="checkbox"/> Re-excision of the biopsy site<br><input type="checkbox"/> Other                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | Treatment Date: ____ / ____ / ____<br>Treatment Provider: _____      |  |
| Case Management Needed: <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | Contact your area screening coordinator                              |  |
| Further Treatment required:<br>Referred to: _____ Phone No: _____ Appt. Date: ____ / ____ / ____<br>ABCCEDP does not pay for treatment, but patient may be eligible for Medicaid Treatment Program.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                      |  |