BREAST DIAGNOSTIC AND FOLLOW-UP FORM
ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

Name: ______ (Last) ______ (First) ______ (Middle) Date of Birth: ____ (mm) / ____ (dd) / ______ (yyyy)

Social Security Number: ______ - ______ - ______ Referring Clinic Provider: ______

Physician/Surgeon: ______ Phone No: ______ Today's Date: ____ / ____ / ______

Reason for Referral: ______

Insurance Status: ❑ No Insurance ❑ Underinsurance ❑ Insured | Billed to Medicaid: ______ Yes

❑ Repeat CBE/Surgical consultation:

Result:
- ❑ Refused/Not done
- ❑ No intervention/routine follow-up
- ❑ Short term follow-up: ______ mos.
- ❑ Biopsy/FNA recommended

Date Performed: ____ / ____ / ______

Provider: ______

❑ Fine Needle Aspiration/Cyst Aspiration

Result:
- ❑ Refused/Not done
- ❑ No fluid or tissue obtained
- ❑ Non-suspicious
- ❑ Suspicious for neoplasm

Date Performed: ____ / ____ / ______

Provider: ______

❑ Biopsy:
- ❑ Surgical
- ❑ Stereotactic
- ❑ Core Needle

Result:
- ❑ Refused/Not done
- ❑ Hyperplasia
- ❑ Other benign changes
- ❑ Lobular Carcinoma In Situ (LCIS)*
- ❑ Carcinoma in situ*
- ❑ Invasive breast cancer*
- ❑ Normal breast tissue
- ❑ Other: ______

* Please contact your ABCCEDP Regional Coordinator as soon as a diagnosis of cancer is known.

Date Performed: ____ / ____ / ______

Provider: ______

❑ Other Tests Performed

If yes, specify: ______

Date Performed: ____ / ____ / ______

Provider: ______

Final Diagnosis:
- ❑ Breast Cancer not diagnosed
- ❑ Ductal Carcinoma In Situ (DCIS)
- ❑ Lobular Carcinoma In Situ (LCIS)
- ❑ Invasive Breast Cancer
- ❑ Other: ______

Date Performed: ____ / ____ / ______

Status of Diagnostic Work-up:
- ❑ Work-up completed
- ❑ Lost to follow-up
- ❑ Work-up refused
- ❑ Work-up pending
- ❑ Irreconcilable*

Date Performed: ____ / ____ / ______

* If the provider refers for short-term follow-up instead of following guidelines.

Treatment Status:
- ❑ Initiated
- ❑ Pending
- ❑ Lost to follow-up
- ❑ Refused
- ❑ Not indicated
- ❑ Updated (follow-up information)

Treatment (not paid by Alabama Breast and Cervical Cancer Program)
- ❑ Mastectomy
- ❑ Lumpectomy
- ❑ Re-excision of the biopsy site
- ❑ Other: ______

Treatment Date: ____ / ____ / ______

Treatment Provider: ______

Case Management Needed: ❑ Yes Contact your regional coordinator

Further Treatment required:

Referred to: ______ Phone No: ______ Appt. Date: ____ / ____ / ______

ABCCEDP does not pay for treatment, but patient may be eligible for Medicaid Treatment Program.