State of California—Health and Human Services Agency

California Department of Public Health

DETEC - BREAST CANCER SCREENING CYCLE DATA

CONFIDENTIAL DATA

Recipient ID# 9 A

Date of Birth ____/____/______ mm/dd/yyyy

Recipient Name: ______________________ Last ______________________ First ________ Middle

Provider ID# ______________________

I Clinical Breast Exam

1. CURRENT Breast Symptoms?
- O Yes
- O Unknown
- O No

2a. Current CBE Results
- O Normal
- O Benign findings
- O* Abnormality suspicious for cancer
- O Not needed
- O Needed but not performed at this visit (includes refused)

*Immediate work-up needed *(Item 8)*

2b. Date of CURRENT CBE ____/____/______ mm dd yyyy

3. ☐ Current results obtained from a non-CDP provider

II Mammogram

4a. PREVIOUS Mammogram?
- O Yes - Date known
- O Yes - Date unknown
- O Unknown - Woman doesn't know
- O Unknown - Woman wasn't asked / not recorded
- O Unknown - Woman refused to answer
- O No

4b. Date of PREVIOUS Mammogram ____/______ mm yyyy

5. Reason for CURRENT Mammogram (See Instruction Sheet)
- O Routine screening mammogram
- O Initial mammogram for symptoms, abnormal CBE, or previous abnormal mammogram
- O✦ No initial mammogram - CBE only or sent to other imaging or diagnostics (Includes refused mammogram)
- O✦ Initial mammogram not paid by CDP - Client referred for diagnostics only (Report mammogram result in Item7)

✦Complete diagnostic referral date *(Item 6)*

(See Instruction Sheet)

6.✦ Breast Diagnostic Referral Date ____/____/____ mm/dd/yyyy

7a. CURRENT Mammogram Result
- O Negative (BI-RADS 1)
- O Benign Finding (BI-RADS 2)
- O✓ Probably Benign (BI-RADS 3)
- O* Suspicious Abnormality (BI-RADS 4)
- O* Highly Suggestive of Malignancy (BI-RADS 5)
- O* Assessment is incomplete (BI-RADS 0) - Needs more imaging
- O* Assessment is incomplete (BI-RADS 0) - Needs film comparison
- O✓ Unsatisfactory

*Immediate work-up needed *(Item 8)*
✓Short term follow-up recommended *(Item 8)*

7b. Date of CURRENT Mammogram ____/____/______ mm dd yyyy

III Additional Procedures Needed to Complete Breast Cycle?

8.
- O Not needed or planned - **Routine rescreen** (Resume annual screenings)
- O✓ Not needed or planned - **Short term follow-up** (Next appointment planned in less than 12 months)
- O* Needed or planned - **Immediate work-up** (Immediate diagnostic work-up is planned)

IV Breast Imaging Procedures • All dates below must be ON or AFTER the Date of CURRENT CBE / Mammogram •

9a. Type of Procedure
- O Additional Mammographic Views
- O Ultrasound
- O Film Comparison to Evaluate an Assessment Incomplete

9b. Date of Procedure ____/____/______ ____/____/______ ____/____/______ (mm dd yyyy)

10a. Final Imaging Outcome
- O Negative (BI-RADS 1)
- O Benign Finding (BI-RADS 2)
- O Probably Benign (BI-RADS 3)
- O Suspicious Abnormality (BI-RADS 4)
- O Highly Suggestive of Malignancy (BI-RADS 5)
- O Unsatisfactory - Radiologist could not read; no final outcome

10b. Date of Final Imaging Outcome ____/____/______ mm dd yyyy

V Breast Diagnostic Procedures

11a. Type of Procedure
- O Repeat Breast Exam
- O Surgical Consultation
- O Biopsy / Lumpectomy
- O Fine Needle / Cyst Aspiration

11b. Date of Procedure ____/____/______ ____/____/______ ____/____/______ (mm dd yyyy)

12a. Other Breast Procedure Performed *(♦ Not Covered by CDP:EWC)* (See Instruction Sheet)
- O♦ MRI
- O♦ Skin biopsy
- O Other medical consults
- O **Other - Please specify** ______________________

12b. Date of Procedure ____/____/______ mm dd yyyy

VI Breast Work-up Status and Final Diagnosis Information

13a. Work-up Status (See Instruction Sheet)
- O Work-up complete
- O Lost to follow-up (Two phone calls and certified letter sent)
- O Work-up refused (Patient refused, obtained insurance, moved, or changed PCP)
- O Died before work-up complete

13b. Date of Work-up Status ____/____/______ mm dd yyyy

14a. Final Diagnosis
- O No Breast Cancer / Benign—resume annual screening
- O No Breast Cancer / Benign—short-term follow-up
- O Lobular Carcinoma In Situ (LCIS)
- O ▶ Ductal Carcinoma In Situ (DCIS)
- O ▶ Invasive Breast Cancer

▶ Treatment Status required if final diagnosis is DCIS or Invasive Breast Cancer *(Item 15)*

14b. Date of Final Diagnosis ____/____/______ mm dd yyyy

VII Breast Cancer Treatment Information

15a. Treatment Status
- O Treatment started
- O Lost to follow-up (Two phone calls and certified letter sent)
- O Treatment refused
- O Treatment not needed
- O Died before treatment started

15b. Date of Treatment Status ____/____/______ mm dd yyyy

16. ☐ Patient enrolled in BCCTP. Check this box ONLY if you have completed the BCCTP enrollment process.

Clinician's Signature (optional) ______________________ **Date** ____________