



Cancer Detection Programs: Every Woman Counts

CBE RESULTS DOCUMENTATION FORM

Pt Name: _____
ID #: _____
DOB: _____

Breast Health History	Purpose of Visit <input type="checkbox"/> Annual screening <input type="checkbox"/> New problem <input type="checkbox"/> Recall <input type="checkbox"/> Short-term F/U ___mos. <input type="checkbox"/> Other: _____	Date of Last CBE _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown	Breast Cancer History Patient: Age at Dx _____ <input type="checkbox"/> N/A Mother: Age at Dx _____ <input type="checkbox"/> N/A Sister(s): Age(s) at Dx _____ <input type="checkbox"/> N/A Daughter(s): Age(s) at Dx _____ <input type="checkbox"/> N/A Aunt(s): Age(s) at Dx _____ <input type="checkbox"/> N/A Male Relative(s): _____ <input type="checkbox"/> N/A <i>specify relationship</i>																																		
	Patient Concerns <input type="checkbox"/> None <input type="checkbox"/> Lump <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Nipple skin retraction <input type="checkbox"/> Erythema / swelling <input type="checkbox"/> Rash / scaling <input type="checkbox"/> Breast pain <input type="checkbox"/> Other: _____	<table border="0"> <tr> <td></td> <td>R</td> <td>L</td> <td>Cyclic</td> <td>Date Pt Found</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> </table>		R	L	Cyclic	Date Pt Found	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Physical Exam	Breast Findings None <input type="checkbox"/> Fine nodularity <input type="checkbox"/> <input type="checkbox"/> Dense nodularity <input type="checkbox"/> <input type="checkbox"/> Skin edema <input type="checkbox"/> <input type="checkbox"/> Nipple/areolar change <input type="checkbox"/> <input type="checkbox"/> Tenderness <input type="checkbox"/> <input type="checkbox"/> Nipple discharge <input type="checkbox"/> <input type="checkbox"/> Mass <input type="checkbox"/> <input type="checkbox"/> Symmetry <input type="checkbox"/> Yes <input type="checkbox"/> No	<table border="0"> <tr> <td></td> <td>R</td> <td>L</td> <td>Depth of Pressure</td> <td>O'Clock</td> <td>Distance from Nipple</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>		R	L	Depth of Pressure	O'Clock	Distance from Nipple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<p>+++ = scar ● = palpable mass /// = dimpling = uncertain thickening</p>
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Discrete Mass Shape <input type="checkbox"/> round <input type="checkbox"/> oval <input type="checkbox"/> irregular Margins <input type="checkbox"/> well-defined <input type="checkbox"/> ill-defined Size <input type="checkbox"/> <5 mm <input type="checkbox"/> 5-9 mm <input type="checkbox"/> 1-2 cm <input type="checkbox"/> 3-4 cm <input type="checkbox"/> >4 cm Texture <input type="checkbox"/> soft <input type="checkbox"/> firm <input type="checkbox"/> rubbery <input type="checkbox"/> hard Mobility <input type="checkbox"/> fixed <input type="checkbox"/> mobile Other <input type="checkbox"/> _____	Lymph Nodes WNL Enlarged Fixed Mobile	Axillary <table border="0"> <tr> <td></td> <td>R</td> <td>L</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clavicular <table border="0"> <tr> <td></td> <td colspan="2">Supra</td> <td colspan="2">Infra</td> </tr> <tr> <td></td> <td>R</td> <td>L</td> <td>R</td> <td>L</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Supra		Infra			R	L	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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Results	CBE Result Date _____ <input type="checkbox"/> Normal <input type="checkbox"/> Benign finding <input type="checkbox"/> Abnormality: suspicious for cancer	Imaging Referral Date _____ <input type="checkbox"/> Screening imaging <input type="checkbox"/> Diagnostic imaging <input type="checkbox"/> Ultrasound (only) <input type="checkbox"/> Other	Patient Education <input type="checkbox"/> Importance of annual screen <input type="checkbox"/> Referral follow-up <input type="checkbox"/> Breast self-examination <input type="checkbox"/> Other
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Overall Summary

Case Management	Clinician Signature for CBE: _____ Date: _____	Date _____ CBE & imaging results concordant _____ CBE & imaging discordant _____ Patient notified of mammogram results _____ Patient informed and referred _____ Referral for risk assessment counseling	Date _____ Radiology/imaging workup _____ Surgical consult _____ Return for CBE in 1 2 3 mos. _____ Return for CBE in 6 mos. _____ Return in one year for annual CBE _____ Other _____	
	Final Diagnosis Date _____ Diagnosis _____	Clinician Signature: _____ Date: _____		