

Instructions for BreastCare Screening Form

Purpose

To provide data on women screened for breast and cervical cancer and to meet CDC data requirements at the initial, annual and subsequent visits.

Used by

Community Health Centers (CHCs) and Area Health Education Centers (AHECs)

Explanations and definitions

Field	Directions
MM/DD/YYYY – Date of Exam	Self-explanatory. NOTE: Use date format of MM/DD/YYYY for all date fields.
Patient's BreastCare ID Number 7777	Enter BreastCare ID number from the client's BreastCare card that begins with four sevens.
Last Name of Patient, First Name of Patient, and MI	Self-explanatory.
Date of Birth	Self-explanatory.
Social Security Number	Self-explanatory. Check N/A if no SSN for client.
Name of Clinic	Enter name of clinic, not an individual's name.
County of Clinic	Enter county where clinic is located.
Does the client report any of the following breast symptoms?	Check Yes and the appropriate box if symptom(s) are reported by patient or check No if client does not report symptoms. Note: Refer for diagnostic mammogram if client reports symptom(s).
Does the client report any of the following cervical symptoms?	Check Yes and appropriate box if symptom(s) are reported by patient or check No if client does not report symptoms. Note: Refer for GYN consultation regardless of Pap test results if client reports symptom(s).
Clinical Breast Exam (Objective Findings)	Check appropriate box/boxes. If abnormal, applicable finding(s) must be checked. Note: Refer for diagnostic mammogram when breast exam is abnormal. Order ultrasound (with mammogram) for palpable mass/thickening.
Pap Test	Check appropriate box/boxes. Check why Pap test was not needed. Note: Liquid based cytology is preferred with ASC-US reflex testing.

Field	Directions
Pelvic Exam	Check appropriate box.
Print Name and Title of Person ...	Print name and title of person performing breast exam and/or Pap test.
Name of Cytology Laboratory for Paps	Enter name of lab that interprets Pap test.
Mammogram Appointment Date/Appointment Time	Enter appt date and time of mammogram.
Name of Mammogram Facility/Town of Facility	Enter name and town where mammogram facility is located.
Check scheduled procedure(s):	Check appropriate box for type of mammogram and/or ultrasound ordered. Check ultrasound when CBE demonstrates palpable mass/thickening.

Mechanics and filing

Complete a BreastCare Screening Form at the initial, annual, and interim visits that require a clinical breast exam or Pap test.

Place original in the patient's record. Fax copy within 5 days of service to BreastCare Data Manager at 501-661-2264.

At each annual visit, remove the previous BreastCare Screening Form and place in supplemental folder.

**ARKANSAS DEPARTMENT OF HEALTH
BREASTCARE SCREENING FORM**

MM/DD/YYYY – Date of Exam		Patient's BreastCare ID Number 7777	
Last Name of Patient		First Name of Patient	MI
Date of Birth	Social Security Number:	Smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes If smoker, <input type="checkbox"/> Referred to Tobacco Quitline <input type="checkbox"/> Refused referral to Quitline	
Name of Clinic		County of Clinic	
<p>Does the client report any of the following breast symptoms?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Check all that apply) <input type="checkbox"/> Palpable mass <input type="checkbox"/> Skin ulceration/inflammation <input type="checkbox"/> Skin dimpling <input type="checkbox"/> Spontaneous nipple discharge <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Focal pain <input type="checkbox"/> Other _____ <p><i>(If yes, refer for diagnostic mammogram)</i></p>		<p>Does the client report any of the following cervical symptoms?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Check all that apply) <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Post menopausal bleeding <input type="checkbox"/> Irregular bleeding <p><i>(If yes, refer for GYN consult regardless of Pap test results)</i></p>	
<p>Clinical Breast Exam (Objective Findings):</p> <input type="checkbox"/> Normal/benign (includes scarring And implants) <input type="checkbox"/> Abnormal (Check abnormality) <input type="checkbox"/> Palpable mass/thickening (refer for US & diagnostic mammogram) <input type="checkbox"/> Skin dimpling/retraction/ inflammation <input type="checkbox"/> Spontaneous nipple discharge observed <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Needed, but not performed (includes refused) <input type="checkbox"/> Not done <p><i>For abnormal CBE, refer for diagnostic mammogram, follow-up required</i></p>		<p>Pap Test: (Check type of Pap Performed) <input type="checkbox"/> Liquid-based with ASC-US Reflex Testing <input type="checkbox"/> Conventional smear</p> <p>Pap not needed because: <input type="checkbox"/> Benign hyst, no cervix <input type="checkbox"/> Pap test in past 12-24 months Date of last Pap _____ <input type="checkbox"/> Negative LBT last year <input type="checkbox"/> 3 Negative/benign consecutive Pap tests in last 5 yrs <input type="checkbox"/> Pap needed, but not performed (includes refused)</p> <p>Note: ASC-US reflex testing for HPV High Risk DNA must be ordered for all liquid-based tests (LBT). HPV High Risk DNA Testing is reimbursable for laboratories.</p>	
<p>Pelvic Exam:</p> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, not suspicious for cancer <input type="checkbox"/> Abnormal, suspicious for cancer <input type="checkbox"/> Not done			
Print Name and Title of Person Performing Pap and/or CBE		Name of Cytology Laboratory for Paps	
Mammogram Appointment Date	Appointment Time	Check scheduled procedure(s): <input type="checkbox"/> Screening Mammogram (film or digital) <input type="checkbox"/> Diagnostic Mammogram (film or digital) <input type="checkbox"/> Ultrasound	
Name of Mammogram Facility		Town of Facility	

Fax Completed Form to 501-661-2264.