**IMAGING BREAST EVALUATION REPORTING FORM**

# Please Print Clearly BCCHP#       Authorization #

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **R****E****F****E****R****R****A****L****S****O****U****R****C****E** | CLIENT NAME (Last, First, MI)      | DATE OF BIRTH      | LAST FOUR SS# (optional)      | DATE OF PROCEDURE      |
| IMAGING FACILITY/SITE      | PREVIOUS IMAGING FACILITY/DATE (COMPARISON)\*      | CHART NUMBER      |
| REFERRING CLINIC SITE      | REFERRING PROVIDER NAME      |
| PRIMARY INSURANCE (IF THERE IS A PRIMARY INSURANCE COVERAGE, PLEASE SUBMIT EOB TO BCCHP FOR ADDITIONAL REIMBURSEMENT UP TO PROGRAM FEE SCHEDULE AMOUNT)Name of insurance company       Policy/Identification number       |
| Type of test ordered:Screening: [ ]  Mammography [ ]  MRI\* \*Approval for high-risk screening MRI requires prior authorization and lifetime risk calculation. **If available, please complete below:**Was the Tyrer-Cuzick (IBIS) model used? \_\_\_\_Yes \_\_\_\_ No If so, Lifetime Risk: \_\_\_\_\_\_\_\_%(20% or higher is considered high risk)* Family history of breast cancer: [ ]  Yes [ ]  No

If yes, Relative type:       Age at dx:      * Positive for BRCA mutation, or first-degree relative [ ]  Yes [ ]  No

Diagnostic: [ ]  R [ ]  L [ ]  Bilateral [ ]  Mammography [ ]  Ultrasound**Personal history of breast cancer**: [ ]  Yes [ ]  No, Age at dx:      **Breast Implants** [ ]  Yes [ ]  No**Ordering Clinician’s Remarks:**       | RightLeft***A mammogram (or additional mammographic views) is not sufficient evaluation of an abnormal CBE.******Palpable breast masses need to be evaluated clinically and/or with ultrasound regardless of mammogram result.*** |
|  | FOR IMAGING FACILITY USE ONLY BELOW THIS LINE |
|  | **Type of Test** | [ ]  Mammography [ ]  Digital |  [ ]  Conventional |  |  [ ]  US | [ ]  MRI |
|  | **Mam** | **US** |  |
|  | **L** | **R** | **L** | **R** |  |
| **BI-RADS Results** | [ ]  | [ ]  | [ ]  | [ ]  | (1) Negative – The breast(s) are symmetric with no masses, architectural distortion or suspicious calcifications present. |
| [ ]  | [ ]  | [ ]  | [ ]  | **(2)** **Benign** – There is nothing to suggest cancer; benign findings that warrant reporting. No evidence of malignancy. |
| [ ]  | [ ]  | [ ]  | [ ]  | **(3) Probably Benign** – Short Interval Follow-up recommended  |
| [ ]  | [ ]  | [ ]  | [ ]  | **(4) Suspicious Abnormality** – Lesions do not have specific characteristics of breast cancer but have a possibility of being malignant. The radiologist has sufficient suspicion to warrant biopsy. |
| [ ]  | [ ]  | [ ]  | [ ]  | **(5) Highly Suggestive of Malignancy** – These lesions have a high probability of malignancy. |
| [ ]  | [ ]  | [ ]  | [ ]  | **(0) Assessment is Incomplete** – Need additional evaluation. (Assessment Incomplete for a mammogram applies only if additional radiological studies are needed) |
| [ ]  | [ ]  | [ ]  | [ ]  | **Technically Unsatisfactory** – Could not be interpreted (needs to be repeated) |
| **Recom-mendations** | **[ ]** Additional Mammographic Views [ ]  Surgical Consult / Repeat Breast Exam[ ]  Ultrasound [ ]  Short Interval Follow-up Suggested in       months[ ]  Fine Needle Aspiration [ ]  Routine Screening Mammogram [ ]  Biopsy [ ]  Obtain Prior Films for Comparison\* |
|  | **COMMENTS:**       |
|  | DIAGNOSTIC PROVIDER SIGNATURE | Print Name      | Telephone Number      | Date      |

**Please FAX form to the BCCHP Prime Contractor at:**