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: _____

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

Date Performed: ____ / ____ / _____

Provider: _____

* Please contact your Area Screening Coordinator as soon as diagnosis of cancer is known.

❑ 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

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 area screening 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.