CANCER SERVICES PROGRAM OF ST. LAWRENCE COUNTY

NAME				DOB:		DATE OF SERVICE:	
	LAST	FIRST	MI		MM/DD/YYYY		MM/DD/YYYY

CLINICAL BREAST EXAM FORM

Review of Patient History

Patient noticed changes in breasts since last visit? Site code _____

No ☐ Yes ☐ Describe_____

Patient has a personal or family history of breast cancer?

No ☐ Yes ☐ Who? _____ What age? _____

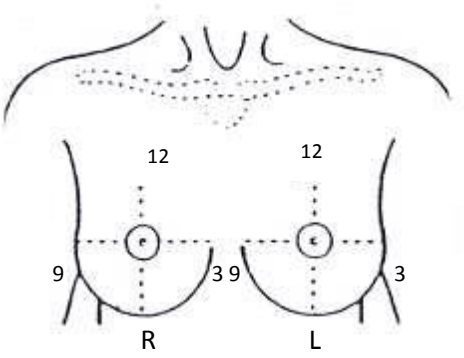
Patient noted spontaneous nipple discharge?

No ☐ Yes ☐ Describe_____

Visual Exam

Skin: Normal/Benign Scar(s) Dimpling
Other:_____

Nipples: Everted Inverted Retraction



Physical Exam:

	Right	Left
Lymph Nodes (Axillary/Clavicular)	☐+ ☐-	☐+ ☐-

Describe all clinical exam findings, including NORMAL and ABNORMAL (indicate size, shape, mobility, location of palpable findings).

Findings: _____

_____

Plan: _____

Referral: No ☐ Yes ☐ (explain) _____

Breast Findings: Check one box only

☐ 1. Normal, Benign, Fibrocystic – Rescreen in 1-2 Years
☐ 2. Probably Benign – Repeat Exam in 3-6 months
☐ 3. Mass or Other Findings – Immediate Testing

_____
Name of Examiner (please print)

_____
Signature of Examiner Date

RETURN COMPLETED FORM & ASSOCIATED MEDICAL REPORTS WITHIN 7 DAYS OF SERVICES RENDERED VIA FAX (315) 261-4728

CANCER SERVICES PROGRAM OF ST. LAWRENCE COUNTY

CLIENT NAME		DOB:		DATE OF SERVICE:	

SCREENING MAMMOGRAM - PLEASE ATTACH RESULTS OF MAMMOGRAM

IF CLIENT UNDER 40 → PREAUTHORIZATION FOR SCREENING MAMMOGRAM REQUIRED
CALL (315) 261-4760 EXT. 225 BEFORE PROCEEDING

SCREENING DATE _____ WHERE DONE _____

- ☐ BIRAD 1 -Negative
- ☐ BIRAD 2 - Benign Finding
- ☐ BIRAD 3 - Probably Benign, short term follow-up
- ☐ BIRAD 4- Suspicious Abnormality Biopsy should be considered
- ☐ BIRAD 5- Highly Suggestive of Malignancy
- ☐ BIRAD 0- Need additional imaging
- ☐ BIRAD 0- Need prior mammogram for comparison
- ☐ Mammogram to be repeated in One Year
- ☐ Mammogram to be repeated in _____ months.
- ☐ Patient has not scheduled an appointment with our office.

CERVICAL SCREENING – PLEASE ATTACH EXAM AND TEST REPORTS

PELVIC EXAM (with PAP) DATE: _____

RESULTS (check one)

- ☐ No Cervix (post-hysterectomy) if this box is checked patient is not eligible for annual pap
- ☐ No findings related to cervical cancer
- ☐ Cervix Suspicious for Cervical Cancer- Immediate Testing- **CALL OFFICE IMMEDIATELY**
- ☐ Not Done - Repeating Pap
- ☐ High Risk HPV Screening **– IF DONE REPORT MUST BE ATTACHED PLEASE ATTACH PATHOLOGY REPORT FOR PAP SMEAR CYTOLOGY**

PAP SMEAR RESULTS:

Test Type:

☐ Conventional ☐ Thin Prep

Test Results:

- ☐ Pap Smear is Not Indicated
- ☐ Pap Smear was Refused
- ☐ Pap Smear was Indicated but not Performed (Refusal)
- ☐ Pap Attempted, No Cervix
- ☐ Negative (within normal limits)
- ☐ (ASCUS) Atypical Squamous Cells of Undetermined Significance
- ☐ Low Grade (SIL) Squamous Intra Epithelial Lesion
- ☐ (Including HPV changes) also worded "Atypia", "Mild (slight) dysplasia / cervical Intra epithelial neoplasia grade 1 (CIN I)", "Cellular changes associated with HPV"
- ☐ High Grade (SIL) Squamous Intra Epithelial Lesion
- ☐ Squamous Cell Cancer
- ☐ A.G.C. - All Subcategories which include adenocarcinoma, endocervical adenocarcinoma in situ, atypical endocervical, atypical endometrial or atypical glandular cells not otherwise specified
- ☐ OTHER - Please Specify _____

Pap smear to be repeated in _____ months.
Please refer to Cervical Cancer Screening Guidelines for when Cancer Services Program can provide reimbursement.

→ IF ANY OTHER TESTS ARE REQUIRED OR IF THERE IS A NEED TO REFER CLIENT TO A GYNECOLOGIST OR A SURGEON, PLEASE CALL THE OFFICE IMMEDIATELY.

EXAMINER SIGNATURE: _____ DATE: _____

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