Patient EHR label

SPIPA
Native Women's Wellness Program
Breast Screening Services

Last Name: _____ **First Name:** _____ **MI:** __ **DOB:** _____ **SSN:**_____
Clinic Location: _____ **Date of Service:** _____

Breast History

Prior Mammogram?: □ Yes Date:_____□ No □ Unknown **Does Pt Have Symptoms today?:** □ Yes □ No

Lifetime Risk Assessment

Breast Cancer Risk:

□ Average □ High □ Not Assessed □ Unknown

Only if high risk, Tyrer-Cuzick (IBIS) model used:

□ Yes □ No

Lifetime Risk: _____% (20% or higher is considered high risk)

Screening MRI

☐ Indicated (High Risk) ☐ Not Indicated (Avg. Risk) ☐Refused

Date of Prior Authorization: _____

Authorized By: _____

Date of Referral:_____

Date MRI Completed: _____

Results Date: _____

Date Patient Notified: _____

**** All program sponsored screening MRIs require prior authorization from SPIPA's NWWP Coordinator or Program Manager****

Clinic Breast Exam (CBE): ☐Completed ☐Refused ☐Not Indicated

Results:

□ Normal Exam
□ Benign findings
□ Discrete palpable mass – suspicious for cancer
□ Discrete palpable mass – NOT suspicious for cancer
□ Bloody/serous nipple discharge
□ Nipple with areolar scaliness
□ Skin dimpling or retraction
□ Not done normal CBE in the last 12 month □ Refused □ Not done □ Unknown

Recommendations:

□ Follow routine screening
□ Short-term follow-up: _____ months
□ Diagnostic Mammogram
□ Ultrasound
□ Biopsy
□ Surgical Consultation Date: _____

Initial Mammogram: ☐Screening ☐Diagnostic

Date Requested:_____

Date Referred: _____

Date Performed:_____

Results Date: _____

Date Pt Notified:_____

Results:

□ Negative (BI-RADS 1)
□ Benign findings (BI-RADS 2)
□ Probably benign (BI-RADS 3)
□ Suspicious abnormality (BI-RADS 4)
□ Highly suggestive of malignancy (BI-RADS 5)
□ Known malignancy (BI-RADS 6)
□ Assessment incomplete (BI-RADS 0)
□ Unsatisfactory □ Refused
□ Not done □ Unknown

Recommendations:

□ Follow routine screening
□ Short-term follow-up: _____ months
□ Diagnostic mammogram
□ Additional Views
□ Ultrasound
□ Biopsy
□ Surgical Consultation
□ Definitive treatment

Case Management:

Work up Status: □ DX Work-up planned □ DX Work-up not planned

Provider Signature: _____

Patient Navigation:

Initial Call Date: _____ Initials: _____

Second Call Date: _____ Initials: _____

Initial Letter Date: _____ Certified Letter Date: _____

Home Visit Date:_____ □ Patient Lost to Follow-up

Patient Navigator Signature: _____

Notes: