



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: _____ **Date:** _____

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: _____ **Date:** _____

Notes: