MONTANA CANCER CONTROL PROGRAMS

MCCP Breast and Cervical Cancer Screening Abnormal Results Form

Client Name	Phone Number	Social Security Number	Date of Birth

MCCP Contact:

Phone **Fax**

Additional Procedures	Date	Results
Imaging Procedures		**Result of Imaging Procedure**
Additional mammographic views	___/___/___	☐ Done _____
Ultrasound	___/___/___	☐ Done _____
Film comparison (to evaluate assessment incomplete)	___/___/___	☐ Done _____
Other: _____	___/___/___	☐ Done _____
Surgical consult, repeat breast exam	___/___/___	☐ Normal ☐ Abnormal _____
Fine needle biopsy/cyst aspiration	___/___/___	☐ Normal ☐ Abnormal _____
Incisional biopsy	___/___/___	☐ Normal ☐ Abnormal _____
Excisional biopsy	___/___/___	☐ Normal ☐ Abnormal _____
Colposcopy directed biopsy/ECC	___/___/___	☐ Normal ☐ Abnormal _____
Diagnostic LEEP	___/___/___	☐ Normal ☐ Abnormal _____
Diagnostic cold knife cone	___/___/___	☐ Normal ☐ Abnormal _____
Diagnostic endocervical curettage	___/___/___	☐ Normal ☐ Abnormal _____
Gyn consult	___/___/___	☐ Normal ☐ Abnormal _____
Other- List: _____	___/___/___	☐ Normal ☐ Abnormal _____

Breast Final diagnosis

- ☐ Cancer not diagnosed
- ☐ Cancer, in-situ - LCIS
- ☐ **Cancer, in-situ - DCIS ****
- ☐ **Cancer, invasive ****

Cervical Final Diagnosis

- ☐ Normal/benign/inflammation
- ☐ HPV/Condylomata/Atypia
- ☐ Mild dysplasia/CIN I (bx dx)
- ☐ Low Grade SIL (bx dx)
- ☐ **Moderate dysplasia/CIN II (bx dx) ****
- ☐ **High Grade SIL (bx dx) ****
- ☐ **Severe dysplasia/CIN III/Carcinoma in situ ****
  (Adenocarcinoma in situ of the cervix (bx dx)
- ☐ **Invasive Cervical Carcinoma (bx dx) ****
- ☐ Other - List: _____

Complete for Breast and/or Cervical Findings

Status of final diagnosis/imaging (date is required)

- ☐ Work-up complete Date ___/___/___
- ☐ Work-up refused Date ___/___/___
- ☐ Lost to follow-up Date ___/___/___

Comments _____

**** Status of treatment (required for bolded final diagnosis)**

- ☐ Started Date ___/___/___
- ☐ Refused Date ___/___/___
- ☐ Lost to follow-up Date ___/___/___

Next Screening or Follow-up due ___/___/___

Provider's signature _____

Provider's name _____