

COMMENTS:	<p>- Affix label here-</p> <p>Clinical Center/ID: _____ - _____ - _____</p> <p>First Name _____ M.I. _____</p> <p>Last Name _____</p>
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1. Contact Date: -- (M/D/Y)

2. Completed By: _____

3. Contact Type:

- ₁ Phone ₃ Visit
- ₂ Mail ₈ Other

4. Visit Type:

- ₁ Screening #
- ₂ Semi-Annual #
- ₃ Annual #
- ₄ Non-Routine

5. Date breast exam performed: -- (M/D/Y)

6. CBE exam performed by:

- ₁ CC Staff
- ₈ Other →

6.1 Report taken by: _____

6.2 MD Name _____

Clinic Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

6.3 Were there any abnormal findings during the breast exam?

₀ No

₁ Yes

6.4 Verbal report provided by (LPN, RN, PA, NP or MD): _____

7. Summary of clinical breast exam (CBE). Also record clinical exam notes.

	Right			Left		
	No	Yes, probably benign	Yes, possibly malignant	No	Yes, probably benign	Yes, possibly malignant
7.1. Nipple discharge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7.2. Skin involvement	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7.3. Axillary mass	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7.4. Breast mass	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		↓	↓		↓	↓
For primary mass:						
	No	Yes		No	Yes	
7.5. Mobile	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	
7.6. Size		<input type="checkbox"/> ₂ < 1 cm			<input type="checkbox"/> ₂ < 1 cm	
		<input type="checkbox"/> ₃ 1-3 cm			<input type="checkbox"/> ₃ 1-3 cm	
		<input type="checkbox"/> ₄ > 3 cm			<input type="checkbox"/> ₄ > 3 cm	
7.7. More than one mass present	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	

8. Breast self-exam (BSE) teaching completed/reinforced?

₀ No ₁ Yes

9. Was a referral made for follow-up care?

₀ No ₁ Yes →

9.1. Referred by: _____

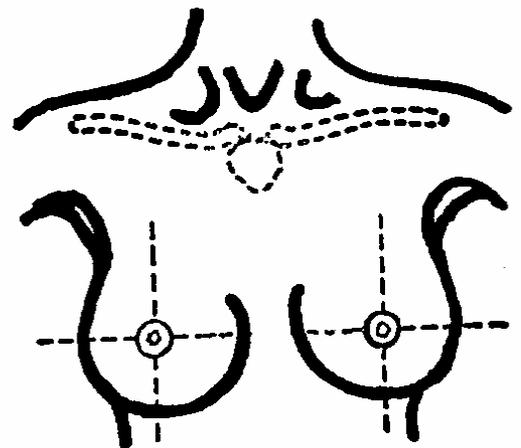
9.2. Date of referral: _____ (M/D/Y)

9.3. Referred to:

MD/Clinic: _____

Address: _____

Phone: _____



10. Final Follow-Up Results

	10.1 Right	10.2 Left
Normal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₀
Benign changes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Possibly malignant	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Cancer	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃