Project WISH—Women Into Staying Healthy
D.C. Department of Health
899 N. Capitol Street, NE
Washington, DC 20002 (202) 442-5900

WISH ID #_____

PROJECT WISH VISIT SUMMARY FORM

Name_____ Date of Birth_____
(Please Print)

Date of Visit_____ Hospital/Clinic_____

Type of Visit: ❑ NEW PATIENT ❑ ANNUAL ❑ SHORT TERM FOLLOW-UP ❑REPEAT EXAM

Breast Summary

1. PRIOR MAMMOGRAM: ❑ No ❑ Unknown
❑ Yes: Date ___/____/____(mm/dd/yyyy) Location_____

2. BREAST SYMPTOMS: ❑ No ❑ Unknown
❑Yes → ❑ Lump ❑ Nipple discharge
❑ Skin changes ❑ Pain
❑ Other _____

3. CLINICAL BREAST EXAM PERFORMED:
❑ Needed, not done ❑Not needed ❑ Refused
❑ Yes (*Complete results below*)
❑ Normal
❑ Benign (fibrocystic, diffuse lumpiness, nodularity)
❑ Abnormal, NOT suspicious for cancer (no diagnostic workup)

❑Abnormal, suspicious for cancer (***workup required 60 days***)
❑ Discrete palpable mass (cystic or solid)
❑ Bloody or serous nipple discharge
❑ Skin dimpling or retraction
❑ Other _____
Question 7: Diagnostic Work-Up Must be Complete

4. MAMMOGRAM ORDERED:
❑ Yes, Where _____ ❑ No, mammogram not needed
Type → ❑ Screening ❑ Diagnostic
DATE OF MAMMOGRAM: ___/____/____

5. INDICATION FOR INITIAL MAMMOGRAM:
❑ Routine Screening ❑ Evaluation of Symptoms
❑ Diagnostic Referral ❑ Initial Mammogram not done
❑ Other _____

6. SCREENING MAMMOGRAM RESULTS:
❑ Negative (BI-RADS 1) ❑ Assessment Incomplete
❑ Benign (BI-RADS 2) ❑ Unsatisfactory
❑ Probably Benign (BI-RADS 3) ❑ Results Pending
❑ Suspicious of Abnormality (BI-RADS 4) ❑ Results Unknown
❑ Highly Suspicious of cancer (BI-RADS 5) ❑ Film Comparison (BI-RADS 0)

7. DIAGNOSTIC WORK-UP:
❑ Planned (***Req. for abn. CBE or Mamm → Complete Breast Diagnostic Form)***
❑ Not needed ❑ Not yet determined

8. BREAST DIAGNOSTIC REFERRAL DATE: __/__/__ (mm/dd/yyyy)

9. MAMM PAID FOR PROJECT WISH FUNDS: ❑ Yes ❑ No ❑ Unknown

10. RECOMMENDATIONS:
❑ Routine screening ❑ Short term F/U in ___ months
❑ Diagnostic Mammogram ❑ Ultrasound
❑ Fine needle aspiration ❑ Biopsy
❑ Surgical Consultation ❑ Repeat Breast Examination
❑ Obtain Definitive Treatment ❑ Other _____

Cervical Summary

1. PRIOR PAP TEST: ❑ No ❑ Unknown
❑Yes: Date___/____/_____ (mm/dd/yyyy) Location_____

2. HYSTERECTOMY: ❑ No ❑ Unknown
❑ Yes: Reason_____ Date __/__/___ (mm/dd/yyyy)

3. PELVIC EXAMINATION PERFORMED:
❑ Yes: Pelvic Results:
❑ Normal
❑ Abnormal-no immediate work-up required

❑ Abnormal- suspicious for cancer (***workup required – 90 days***)
❑ Other _____
Question 13: Diagnostic Work-Up Must be complete

❑ Needed, not done ❑ Not needed ❑ Refused

4. INDICATION FOR PAP TEST:
❑ Routine Pap Test ❑ Unknown
❑ Surveillance for previous abnormal
❑ Pap test not done, Diagnostic work-up or HPV testing
❑ Pap done outside of program

5. CERVICAL DIAGNOSTIC REFERRAL DATE: __/__/__ (mm/dd/yyyy

6. PAP TEST PERFORMED & SOURCE:
❑ Yes → ❑Cervix ❑Vagina ❑Other_____
❑ Needed, not done ❑ Not Needed ❑ Refused

7. PAP PAID FOR W/PROJECT WISH FUNDS: ❑ Yes ❑ No ❑ Unknown

8. PAP TEST SPECIMEN TYPE:
❑ Conventional Smear ❑ Other_____
❑ Liquid Based (Thin Prep) ❑ Unknown

9. PAP TEST SPECIMEN ADEQUACY:
❑ Satisfactory ❑ Unsatisfactory ❑Unknown

10. PAP TEST RESULTS:
❑ Negative ❑ ASC-US ❑ Pending
❑ Low grade SIL ❑ ASC-H ❑ Results unk, presumed abn.
❑ High grade SIL ❑ Abnormal Glandular Cells
❑ Squamous Cell Cancer ❑ Other ❑ Refused

11. HPV/DNA: ❑ Not Needed
❑ Yes: Date: __/__/__ (mm/dd/yyyy) ❑ Positive ❑ Negative ❑ Unk.

12. HPV PAID FOR PROJECT WISH FUNDS: ❑ Yes ❑ No ❑ Unknown

13. DIAGNOSTIC WORK-UP:
❑ Planned (***Required for abnormal Pap → Complete Cervical Diagnostic Form***)
❑ Not needed ❑ Not yet determined

14. RECOMMENDATIONS:
❑ Routine screening ❑ Short term F/U in ___ months
❑ Repeat Pap immediately ❑ Gynecological consult
❑ Colposcopy directed biopsy ❑ Other _____

Clinician Name: **Signature:** **Date:**