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 BREAST DIAGNOSTIC FORM

Name_____ Date of Birth_____

Date of Visit_____ Hospital/ Clinic_____

ALL SECTIONS MUST BE COMPLETED

DIAGNOSTIC MAMMOGRAM: ❑ Yes ❑ No

❑ Unilateral ❑ Bilateral ❑ Conventional ❑ Digital

Procedure Date _____/_____/_____ (mm/dd/yyyy)
Procedure site: _____

RESULTS:
❑ Assessment Incomplete ❑ Highly Suspicious of cancer
❑ Negative ❑ Film Comparison needed
❑ Benign ❑ Unsatisfactory
❑ Probably Benign ❑ Refused
❑ Suspicious of Abnormality ❑ Results unk, presumed abn, non-program funded
❑ Results Pending ❑ Other _____

ADDITIONAL VIEWS: ❑ Yes ❑ No

❑ Unilateral ❑ Bilateral ❑ Conventional ❑ Digital

Procedure Date _____/_____/_____ (mm/dd/yyyy)
Procedure site: _____

Results
❑ Assessment Incomplete ❑ Highly Suspicious of cancer
❑ Negative ❑ Film Comparison
❑ Benign ❑ Unsatisfactory
❑ Probably Benign ❑ Refused
❑ Suspicious of Abnormality ❑ Results unk, presumed abn, non-program funded
❑ Results Pending ❑ Other _____

Ultrasound: ❑ Yes ❑ No

Procedure Date ___/___/___ (mm/dd/yyyy)
Procedure site: _____

Results
❑ Normal (WNL) ❑Cystic Mass
❑ Other Benign Abnormality
❑Suspicious of cancer ❑ Refused

Fine Needle/Cyst Aspiration: ❑ Yes ❑ No

Procedure Date ___/___/____ (mm/dd/yyyy)
Procedure site: _____

Results
❑ Not Suspicious of cancer ❑Suspicious of cancer
❑ No Fluid/Tissue Collected ❑Refused

OTHER PROCEDURES PERFORMED: ❑ Yes ❑ No **Specify:** _____

Procedure Date ___/___/___ (mm/dd/yyyy)
Procedure site: _____

Results
❑ Normal (WNL) ❑Cystic Mass
❑ Other Benign Abnormality
❑Suspicious of cancer ❑ Refused

Biopsy/Lumpectomy: ❑ Yes ❑ No

Procedure Date ____/_____/_____ (mm/dd/yyyy)
Type of Biopsy: ❑ Excisional ❑ Non-Excisional
Procedure site: _____

Results:
❑ Normal breast tissue ❑ Hyperplasia
❑ Other benign changes ❑ DCIS
❑ LCIS ❑ Invasive Cancer
❑ Refused

Film Comparison: ❑ Yes ❑ No

Procedure Date ___/____/____ (mm/dd/yyyy)
Procedure site: _____

Results:
❑ Negative ❑ Benign
❑ Probably Benign ❑ Suspicious Abnormality
❑ Highly Suggestive of cancer
❑ Unsatisfactory ❑ Refused

Repeat CBE/Surgical Consult ❑ Yes ❑ No

Procedure Date ____/____/____ (mm/dd/yyyy)
Procedure site: _____

Results (Repeat CBE Only):
❑ Negative ❑ Benign
❑ Discrete Palpable Mass ❑ Refused
❑ Bloody or Serious Nipple Discharge
❑ Nipple/ Areolar Scaliness
❑ Skin Dimpling or Retraction ❑ Other _____

BREAST OUTCOME

STATUS OF FINAL DIAGNOSIS: ❑ Work-up Complete ❑ Work-up Pending ❑ Lost to Follow-up ❑ Refused ❑ Deceased

DATE OF STATUS OF FINAL DIAGNOSIS: ____/____/_____(mm/dd/yyyy)

FINAL IMAGING OUTCOME
❑ Additional images pending ❑ Benign
❑ Negative ❑ Highly suspicious of cancer
❑ Suspicious Abnormal, Consider biopsy ❑ No Add'l Imaging Performed
❑ Unsatisfactory ❑ Other _____

DATE OF FINAL IMAGING OUTCOME ____/____/_____(mm/dd/yyyy)

FINAL DIAGNOSIS:
❑ Breast Cancer Not Diagnosed ❑ Ductal Carcinoma In Situ
❑ Lobular Carcinoma In Situ ❑ Invasive Carcinoma
❑ Other _____

DATE PATIENT NOTIFIED OF RESULTS: ____/____/_____(mm/dd/yyyy)
❑ Lost to Follow-up (determined after at least three tries)**STATUS OF**

TREATMENT:
❑ Treatment Started ❑ Lost to Follow-up
❑ Treatment Pending ❑ Refused
❑Treatment Not Needed

DATE OF STATUS OF TREATMENT: ____/____/_____(mm/dd/yyyy)
(Date when treatment began, treatment refused, lost to follow-up, etc.)

Medicaid Enrollment (If Diagnosed):
❑ DC Medicaid ❑ No, Why Not_____

Patient Transferred to: ❑ VA Medicaid/BCCEDP

Clinician Comments:

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