COMMENTS:	- Affix label here- Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name ____________________ M.I. ______ Last Name ____________________________

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): ________

   ____

K ____________ V ____________

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	☐ 0	☐ 1	☐ 2	☐ 0	☐ 1	☐ 2
7.2. Skin involvement	☐ 0	☐ 1	☐ 2	☐ 0	☐ 1	☐ 2
7.3. Axillary mass	☐ 0	☐ 1	☐ 2	☐ 0	☐ 1	☐ 2
7.4. Breast mass	☐ 0	☐ 1 ↓	☐ 2 ↓	☐ 0	☐ 1 ↓	☐ 2 ↓

For primary mass:

	Right		Left	
	No	Yes	No	Yes
7.5. Mobile	☐ 0	☐ 1	☐ 0	☐ 1
7.6. Size	☐ 2 < 1 cm ☐ 3 1-3 cm ☐ 4 > 3 cm		☐ 2 < 1 cm ☐ 3 1-3 cm ☐ 4 > 3 cm	
7.7. More than one mass present	☐ 0	☐ 1	☐ 0	☐ 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)

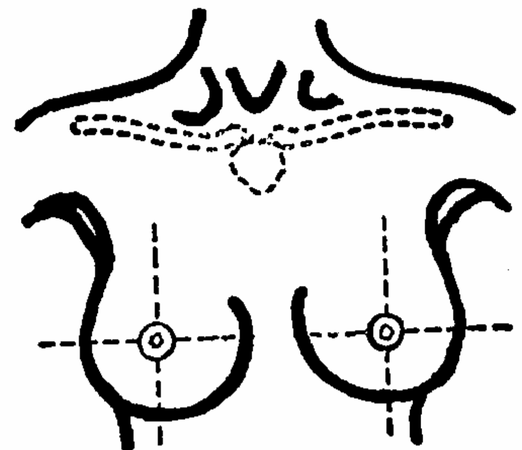
9.3. Referred to:

MD/Clinic: ______________________________

Address: ______________________________

____

Phone: ______________________________



10. Final Follow-Up Results

	10.1 Right	10.2 Left
Normal	☐ 0	☐ 0
Benign changes	☐ 1	☐ 1
Possibly malignant	☐ 2	☐ 2
Cancer	☐ 3	☐ 3