MAMMOGRAPHY AND ULTRASOUND REFERRAL FORM

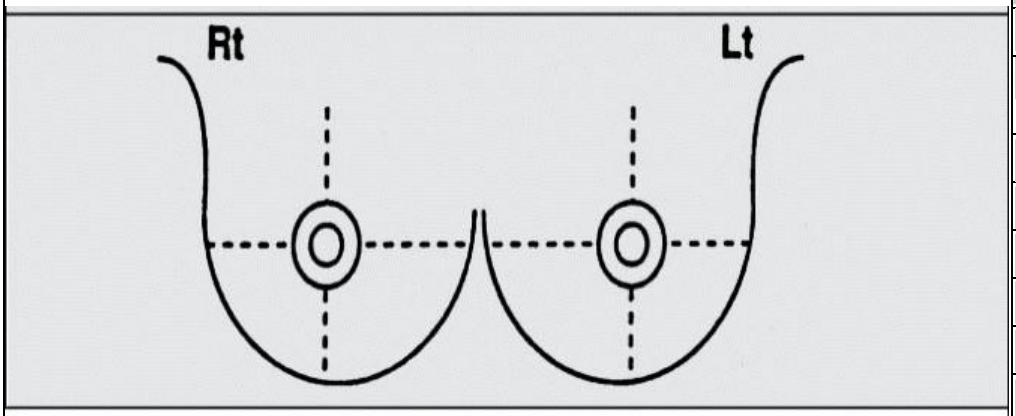
Women's Health Connection (WHC) in Partnership with
Access to Healthcare Network

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Last name:		First name:			
Date of birth (MM/DD/YY):		Age:		WHC member ID:	
Date of appt. (MM/DD/YY):		Imaging facility:			

CLINICAL BREAST EXAM (CBE) FINDINGS

Please indicate abnormality and size on diagram below



CBE Results:

- ☐ Normal
- ☐ Focal pain/tenderness
- ☐ Benign (fibrocystic changes, diffuse lumpiness or nodularity)
- ☐ Bloody/serous nipple discharge
- ☐ Discrete palpable mass-suspicious for cancer
- ☐ Discrete palpable mass-previous diagnosed as benign
- ☐ Nipple/areolar scaliness
- ☐ Not preformed (Explain in notes)
- ☐ Refused
- ☐ Skin dimpling/retraction

Primary care provider:

Date of CBE (MM/DD/YY):

REASON FOR IMAGING

Did patient have previous screening mammogram?	☐ Yes	☐ No	Date of mammogram (MM/DD/YY):

Location:

- ☐ Routine screening mammogram (**only for patients age 40+)**
- ☐ Diagnostic mammogram and/or ultrasound (**only for patients age 40+ with an abnormal CBE result**)
- ☐ Diagnostic mammogram (**only for patients age 40+ with abnormal CBE results**)
- ☐ Ultrasound (**only for patients age 40+ with abnormal CBE results**)
- ☐ MRI (**For high risk women**)
- ☐ Mammary ductogram or galactogram
- ☐ Imaging done outside WHC, patient referred for diagnostic services only

Referral date (MM/DD/YY):

Imaging results:

- ☐ Additional mammographic views
- ☐ Film comparison to evaluate and assess incomplete mammogram

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PRIMARY CARE PROVIDER MUST GIVE PATIENT A COPY OF THIS FORM TO TAKE TO APPOINTMENT

Ordering clinician signature:

Issue date (MM/DD/YY):

PLEASE FAX ALL ABNORMAL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received (MM/DD/YY):

WHC member ID:

Date entered (MM/DD/YY):

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1-844-469-4934 | accesstohealthcare.org
4001 S. Virginia Street, Suite F | Reno, NV 89502