BREAST SPECIALIST 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):

Primary care provider:	Phone [ex. (111) 111-1111]:

CONTACT AN AHN CARE COORDINATOR AT 844-469-4930 TO SCHEDULE AN APPOINTMENT WITH THE SPECIALIST

Specialist Name:	Appointment date (MM/DD/YY):

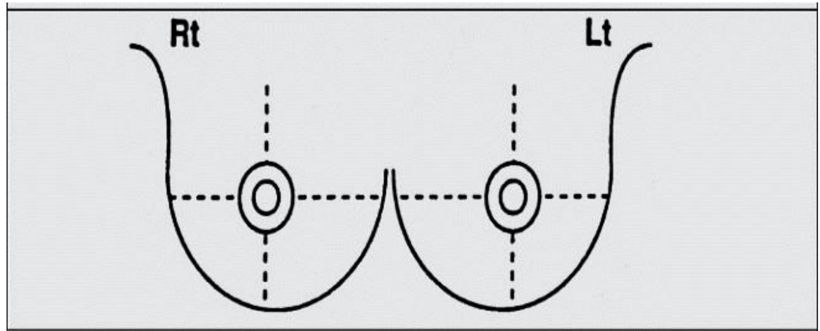
CLINICAL BREAST EXAM (CBE) AND DIAGNOSTIC EVALUATION FINDINGS

CBE Results:

- ☐ Normal
- ☐ Benign (including fibrocystic changes)
- ☐ Discrete palpable mass- suspicious for cancer
- ☐ Bloody/serous nipple discharge
- ☐ Nipple/areolar scaliness
- ☐ Skin dimpling/retraction

Date of CBE (MM/DD/YY)

Please indicate abnormality and size on the diagram below



Imaging Results :

Date of Imaging (MM/DD/YY)

☐ **Screening MRI**	☐ **Diagnostic Mammogram/Ultrasound**
☐ BI-RADS 0	☐ BI-RADS 0
☐ BI-RADS 1	☐ BI-RADS 1
☐ BI-RADS 2	☐ BI-RADS 2
☐ BI-RADS 3	☐ BI-RADS 3
☐ BI-RADS 4	☐ BI-RADS 4
☐ BI-RADS 5	☐ BI-RADS 5
☐ BI-RADS 6	☐ BI-RADS 6
☐ Unsatisfactory result	☐ Unsatisfactory result

Primary Clinician Signature:

Date (MM/DD/YY):

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TO BE COMPLETED BY SPECIALIST FOR EACH OFFICE VISIT

☐ Consult Repeat CBE	☐ Diagnostic procedures recommended/performed
☐ Normal exam	☐ Cyst aspiration
☐ Benign	☐ Fine Needle Aspiration (FNA)
☐ Discrete palpable mass- suspicious for cancer	☐ Fine Needle Aspiration with imaging
☐ Bloody/serous nipple discharge	☐ Percutaneous vacuum biopsy with imaging
☐ Nipple/Areolar scaliness	☐ Needle core biopsy
☐ Skin dimpling/retraction	☐ Needle core biopsy with imaging
Date of Service (MM/DD/YY):	☐ Stereotactic biopsy
☐ Surgical Consultation	☐ Excisional biopsy
☐ Review results/discuss follow up	☐ *Ultrasound
☐ Biopsy/FNA recommended	☐ Ductogram or Galactogram
☐ No intervention- Routine follow up	☐ *MRI
☐ Short term follow up in months	***Prior authorization required**
☐ Surgery or TX recommended	Date of Service (MM/DD/YY):

Date of Service (MM/DD/YY):

☐ Final Diagnosis	☐ Treatment Status
☐ Known malignancy	☐ Treatment not needed
☐ Cancer not diagnosed-follow routine screening	☐ Treatment refused
☐ Lobular carcinoma in situ (LCIS)	☐ Treatment started
☐ Ductal carcinoma in situ (DCIS)	
☐ Invasive breast cancer	
☐ Cancer not diagnosed-short term f/up in months	Treatment facility:
☐ Cancer not diagnosed-short term f/up in months with mammogram and/or ultrasound	Date treatment started (MM/DD/YY):
Date of Service (MM/DD/YY):	

Specialist signature:

Date (MM/DD/YY):

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

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received (MM/DD/YY):	Date entered (MM/DD/YY):	CaST ID#:

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