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

MAMMOGRAPHY AND ULTRASOUND REFERRAL FORM

TO BE COMPLETED BY PRIMARY CARE PROVIDER

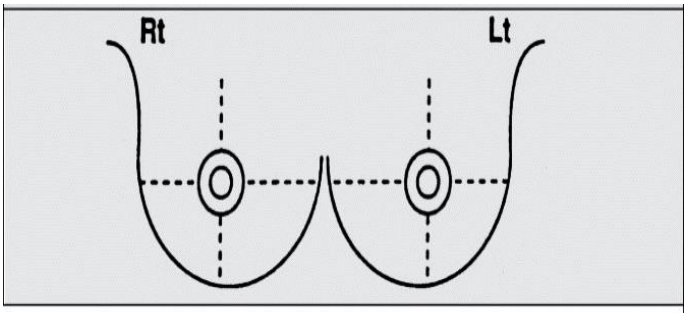
Last Name:_____ **First:** _____

Date of birth: (MM/DD/YYYY) _____ **Age:** _____ **WHC Member ID: 19**_____

Date of Appt.: (MM/DD/YYYY) _____ **Imaging Facility:**_____

CLINICAL BREAST EXAM (CBE) FINDINGS

Please indicate abnormality and size on diagram below



Primary Care Provider:_____

CBE Results:

□ Normal

□ Benign (fibrocystic changes, pain & tenderness)

□ Bloody/serous nipple discharge

□ Discrete palpable mass-suspicious for cancer

□ Discrete palpable mass-previous diagnosed as benign

□ Nipple/areolar scaliness

□ Not performed (Explain in notes)

□ Refused

□ Skin dimpling/retraction

Date of CBE (MM/DD/YYYY): _____

REASON FOR IMAGING

Did client have previous screening mammogram? □ Yes □ No

Date of mammogram (MM/DD/YYYY): _____ Location: _____

□ Routine screening mammogram (**Only for clients age 40+**)

□ Diagnostic mammogram and/or ultrasound (**Only for clients age 40+ with an abnormal CBE results)**

□ Diagnostic mammogram (**Only for clients age 40+ with an abnormal CBE results)**

□ Ultrasound (**Only for clients age 40+ with an abnormal CBE results**)

□ Mammary ductogram or galactogram

□ Imaging done outside WHC, client referred for diagnostic services only Referral Date (MM/DD/YYYY):
Imaging results:

□ Additional Mammographic Views

□ Film comparison to evaluate and Assessment Incomplete Mammogram

□ Under Surveillance- Birad 3 (Short term follow up) Diagnostic mammogram and/or ultrasound

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

Ordering Clinician Signature:_____ **Issue Date** (MM/DD/YYYY):_____

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:

Date entered:

CaST ID#:

0	3	2	0	0	1								