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: ___________________________  CaST ID#: 032001
Date entered: ___________________________