MAMMOGRAPHY AND ULTRASOUND REFERRAL FORM

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

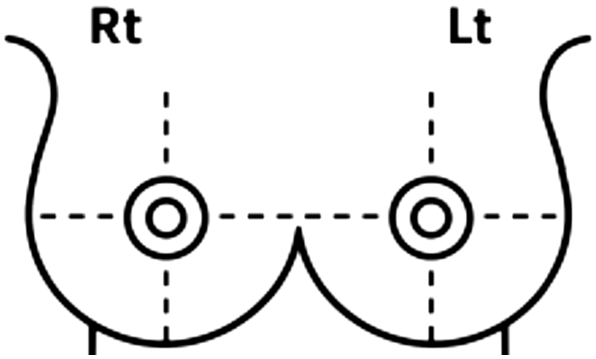
Women's Health Connection (WHC) in Partnership
with Access to Healthcare Network

TO BE COMPLETED BY PRIMARY CARE PROVIDER		
Last name:	First Name:	
Date of birth (mm/dd/yyyy):	Age:	WHC member ID:
Date of appointment (mm/dd/yyyy):	Imaging Facility:	

CLINICAL BREAST EXAM (CBE) FINDINGS

CBE Results:
- ☐ Normal
- ☐ Focal pain/tenderness
- ☐ Benign (fibrocystic changes, diffuse lumpiness or nodularity)
- ☐ Bloody/serious nipple discharge
- ☐ Discrete palpable mass – suspicious for cancer
- ☐ Discrete palpable mass – previously diagnosed as benign
- ☐ Nipple/areolar scaliness
- ☐ Skin dimpling/retraction
- ☐ Not performed (explain in notes)
- ☐ Refused

Please indicate abnormality and size on diagram below



Primary care provider:

Date of CBE (mm/dd/yyyy):

REASON FOR IMAGING

Did the patient have previous screening mammogram? ☐ Yes ☐ No Date of mammogram (mm/dd/yyy):

Location:

- ☐ Routine screening mammogram (only for patients age 40+)
- ☐ Diagnostic mammogram and/or ultrasound (only for patients age 40+ with an abnormal CBE results)
- ☐ 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/yyyy):

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/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 (mm/dd/yyyy):
WHC member ID:
Date entered (mm/dd/yyyy):

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