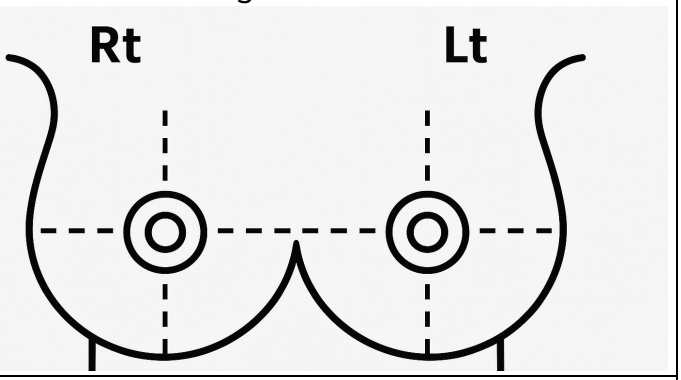
BREAST SPECIALIST REFERRAL FORM

WOMEN'S HEALTH CONNECTION (WHC) IN PARTNERSHIP
WITH ACCESS TO HEALTHCARE NETWORK (AHN)

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

TO BE COMPLETED BY THE PRIMARY CARE PROVIDER (PCP)		
Last Name:	First Name:	DOB (MM/DD/YY):
PCP Name:	PCP Phone [ex. (111) 111-1111]:	
CONTACT AHN AT 844-469-4930 TO SCHEDULE AN APPOINTMENT WITH A SPECIALIST		
Specialist Name:	Appointment Date (MM/DD/YY):	
CLINICAL BREAST EXAM (CBE) AND DIAGNOSTIC EVALUATION FINDINGS		

CBE Results	Please indicate abnormality and size on the diagram below
☐ Normal	
☐ Benign (including fibrocystic changes)	
☐ Discrete palpable mass – suspicious for ca.	
☐ Bloody/serous nipple discharge	
☐ Nipple/areolar scaliness	
☐ Skin dimpling/retraction	
Date of CBE (MM/DD/YY):	

☐ **Screening Magnetic Resonance Imaging (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

Date of Imaging (MM/DD/YY):	
Primary Clinician Signature:	Date (MM/DD/YY):

Breast Specialist Referral Form – Effective July 1st, 2025

access to HEALTHCARE NETWORK

TO BE COMPLETED BY THE SPECIALIST FOR EACH OFFICE VISIT	
☐ **Consult Repeat CBE**	☐ **Diagnostic procedures recommended/performed**
☐ Normal	☐ Cyst aspiration
☐ Benign (including fibrocystic changes)	☐ Fine Needle Aspiration (FNA)
☐ Discrete palpable mass – suspicious for ca.	☐ FNA with imaging
☐ Bloody/serous nipple discharge	☐ Percutaneous vacuum biopsy with imaging
☐ Nipple/areolar scaliness	☐ Needle core biopsy
☐ Skin dimpling/retraction	☐ Needs 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 treatment recommended	Date of Service (MM/DD/YY):
Date of Service (MM/DD/YY):	
☐ **Final Diagnosis (Dx)**	☐ **Treatment (Tx) Status**
☐ Known malignancy	☐ Tx not needed
☐ Cancer not Dx – follow routine screening	☐ Tx refused
☐ Lobular carcinoma in situ (LCIS)	☐ Tx started
☐ Ductal carcinoma in situ (DCIS)	Tx facility:
☐ Invasive breast cancer	Date Tx started (MM/DD/YY):
☐ Cancer not Dx – short term follow up in __ months	
☐ Cancer not Dx – short term follow up in __ months with mammogram and/or ultrasound	
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	
WHC OFFICE USE ONLY	
Date received (MM/DD/YY):	Date entered (MM/DD/YY):
MED-IT ID #:	

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