

WOMEN'S HEALTH CONNECTION (WHC) BREAST IMAGING REFERRAL FORM

NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH



TO BE COMPLETED BY THE PRIMARY CARE PROVIDER (PCP)		
Last Name:		First Name:
DOB (mm/dd/yyyy):	Age:	WHC Member ID:
Date of appointment (mm/dd/yyyy):		Imaging Facility:
CLINICAL BREAST EXAM (CBE) FINDINGS		
Normal Focal pain / tenderness Benign (fibrocystic changes, diffuse lumpiness or nodularity) Bloody / serous 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 the diagram below. Rt Lt
Date of CBE (mm/dd/yyyy):		PCP Name:
REASON FOR IMAGING		
Did the patient have previous screening mammogram? Yes No		
Date of mam. (mm/dd/yyyy):		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)		

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REASON FOR IMAGING CONTINUED		
MRI (for high-risk women)		
Mammary ductogram or galactogram		
Imagine 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		
ATTENTION: PRIMARY CARE PROVIDER PLEASE PROVIDE THE PATIENT A COPY OF THIS FORM		
Ordering clinician signature:	Issue date (mm/dd/yyyy):	
PLEASE FAX ALL ABNORMAL RESULTS TO A WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918		
WHC OFFICE USE ONLY		
Date received (mm/dd/yyyy):	Date entered (mm/dd/yyyy):	WHC Member ID:

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