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

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

TO BE COMPLETED BY THE PRIMARY PROVIDER (PCP)

Last Name:	First Name:	DOB (mm/dd/yyyy):
PCP Name:	PCP Phone:	

CONTACT AHN AT 844-469-4930 TO SCHEDULE AN APPOINTMENT WITH A SPECIALIST

Specialist Name:	Appointment date (mm/dd/yyyy):

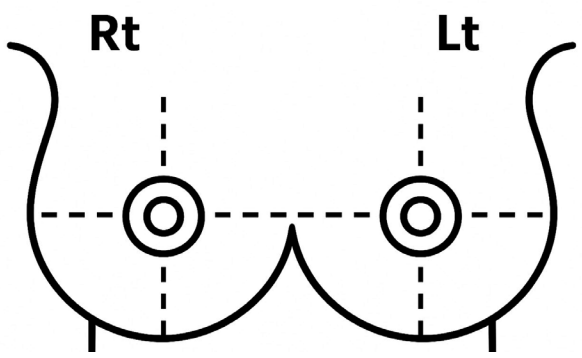
CLINICAL BREAST EXAM (CBE) AND DIAGNOSTIC EVALUATION FINDINGS

CBE Results

- ☐ Normal
- ☐ Benign (including fibrocystic changes)
- ☐ Discrete palpable mass – suspicious for cancer
- ☐ Bloody / serous nipple discharge
- ☐ Nipple / areolar scaliness
- ☐ Skin dimpling / retraction

Date of CBE (mm/dd/yyyy):

Please indicate abnormality and size on the diagram below.



Screening Magnetic Resonance Imaging (MRI)	Diagnostic Mammogram / Ultrasound (US)
☐ 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/yyyy):

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CBE AND DIAGNOSTIC EVALUATION FINDINGS (CONTINUED)

Primary Clinician signature:	Date (mm/dd/yyyy):

TO BE COMPLETED BY THE SPECIALIST FOR EACH OFFICE VISIT

Consult Repeat CBE

- ☐ Normal
- ☐ Benign (including fibrocystic changes)
- ☐ Discrete palpable mass – suspicious for cancer
- ☐ Bloody / serous nipple discharge
- ☐ Nipple / areolar scaliness
- ☐ Skin dimpling / retraction

Date of service (mm/dd/yyyy):

Diagnostic Procedures Recommended / Performed

- ☐ Fine Needle Aspiration (FNA)
- ☐ Stereotactic biopsy
- ☐ Ultrasound-guided biopsy
- ☐ Lymph node biopsy
- ☐ Excisional biopsy
- ☐ Ductogram or Galactogram
- ☐ Ultrasound (US)
- ☐ MRI

Note: All procedures require prior authorization.

Date of service (mm/dd/yyyy):

Surgical Consultation

- ☐ Review results / discuss follow-up
- ☐ Biopsy / FNA recommended
- ☐ No intervention – routine follow-up
- ☐ Short term follow-up in months
- ☐ Surgery or treatment recommended

Date of service (mm/dd/yyyy):

Final Diagnosis (Dx)

- ☐ Known malignancy
- ☐ Cancer not Dx – follow routine screening
- ☐ Lobular carcinoma in situ (LCIS)
- ☐ Cancer not Dx – short term follow-up in months with mammogram and/or ultrasound
- ☐ Ductal carcinoma in situ (DCIS)
- ☐ Invasive breast cancer
- ☐ Cancer not Dx – short term follow-up in months

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Final Diagnosis (Dx) Continued	
Date of service (mm/dd/yyyy):	
Treatment (Tx) Status	
☐ Tx not needed	☐ Tx started
☐ Tx refused	
Date Tx started (mm/dd/yyyy):	Tx facility:
Notes:	
Specialist signature:	Date (mm/dd/yyyy):
PLEASE FAX ALL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918	

WHC OFFICE USE ONLY		
Date received (mm/dd/yyy):	Date entered (mm/dd/yyyy):	Med-IT ID#:

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