ARKANSAS DEPARTMENT OF HEALTH
BREASTCARE

CARE COORDINATOR REFERRAL FORM

Patient Name:_____ SSN/EHR#:_____

Date:_____ Region:_____ Primary Language:_____

Referring Facility:_____ Contact:_____

ID# 7777_____ Exp. Date:_____ Plan:_____ DOB:_____

Address:_____

City:_____ State: AR ZIP:_____

Home Phone:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Reason for Referral:

- ❑ Category 4 Mammogram - Suspicious, recommend biopsy
- ❑ Category 5 Mammogram - Highly Suspicious for Malignancy
- ❑ Ultrasound - Solid mass/suspicious for cancer
- ❑ Abnormal CBE requiring biopsy
- ❑ Pap test requiring colposcopy/consult:
  - o LGSIL/mild dysplasia
  - o AGC
  - o HGSIL/severe dysplasia
  - o Squamous cell carcinoma
  - o Moderate dysplasia
  - o ASC-H
  - o CIS (carcinoma-in-situ)
  - o AEC (atypical endocervical cells)
  - o ASC-US/HPV Positive
  - o HPV 16 or 18 Positive (≥ 30 y.o.)
- ❑ Non-compliant or refusing recommended follow-up of abnormal results.
- ❑ Cervical Pre-cancer - HGSIL (CIN II/III), CIS on cervical biopsy
- ❑ Cervical Cancer
- ❑ Breast Cancer
- ❑ Other_____ ❑ Post-menopausal Bleeding
- ❑ Repeat Pap ≥ ASC-US or HPV positive (follow 5-year Pap Track algorithm)

Records/Reports Attached: PLEASE CIRCLE

∗Mammogram ♦ Pap/HPV Ultrasound Pathology MD Visit ●HIPAA ●Release of Information

∗Required with Mammogram Referral ♦Required with Pap Referral ●Required

Other Remarks: _____

CARE COORDINATOR USE ONLY

MD Name and #: _____

Date Referral Form Received: _____

Date of Initial Contact:_____

- ❑ Closed to CM
- ❑ Send to Central Office (all CM referrals)

Send to:_____ Regional Care Coordinator

Phone:_____

Fax:_____

BC-2 (R 8/19)