

**ARKANSAS DEPARTMENT OF HEALTH
BREASTCARE**

CARE COORDINATOR REFERRAL FORM

Patient Name: _____ SSN: _____

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:
 - LGSIL/mild dysplasia
 - AGC
 - HGSIL/severe dysplasia
 - Squamous cell carcinoma
 - Moderate dysplasia
 - ASC-H
 - CIS (carcinoma-in-situ)
 - AEC (atypical endocervical cells)
 - ASC-US/ HPV Positive
- Non-compliant or refusing recommended follow-up of abnormal results.
- Cervical Precancer - HGSIL (CIN II/III), CIS on cervical biopsy
- Cervical Cancer
- Breast Cancer
- Other _____ Post-menopausal Bleeding
- Repeat Pap \geq 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: _____

<p>CARE COORDINATOR USE ONLY</p> <p>MD Name and #: _____</p> <p>Date Referral Form Received: _____</p> <p>Date of Initial Contact: _____</p> <ul style="list-style-type: none"><input type="checkbox"/> Closed to CM<input type="checkbox"/> Send to Central Office (all CM referrals)
--

Send to: _____ Regional Care Coordinator

Phone: _____

Fax: _____