

**ARKANSAS DEPARTMENT OF HEALTH
BreastCare Program**

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 diagnostic procedures
- Cervical Precancer - HGSIL (CIN II/III), CIS on cervical biopsy
- Cervical Cancer
- Breast Cancer
- Other _____

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: _____