West Virginia Breast and Cervical Cancer Screening Program
Referral Form

All results plus the Radiology or Cervical Diagnostic Reports must be mailed to the screening provider and a copy must be forwarded with the invoice to the WVBCCSP. See bottom of form for the WVBCCSP's address.

Screening Facility: ______________________________ WVBCCSP #: ______________

Screening Clinician: ______________________________ Referral Date: _____ /_____ /_____

Telephone: ( ) ______________________

Client Name (Last, First, MI): ______________________________

Social Security #: ________-________-________ Date of Birth: _____ /_____ /_____

PROVIDER TO WHOM REFERRED

Referral Provider : ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) ____________

Date of Appointment: _____ /_____ /_____ Time of Appointment: ____________

BREAST REFERRAL FOR:

- □ Screening mammogram
- □ Screening mammogram—unilateral
- □ Diagnostic mammogram—bilateral
- □ Diagnostic mammogram-unilateral
- □ Breast biopsy
- □ Fine needle aspiration
- □ Puncture aspiration of cyst
- □ Surgical consultation
- □ Ultrasound: *Reimbursement only when performed within one month of mam*
  Date of mammogram: ______ /______ /______

Reimbursement rendered for approved CPT codes ONLY.

CBE RESULTS

Date Performed: _____ /_____ /_____

- □ Benign findings
- □ Bloody/Serous Nipple Discharge
- □ Discrete Palp Mass (Dx Benign)
- □ Discrete Palp Mass (Susp for Cancer)
- □ Nipple/Areolar Scaliness
- □ Normal Exam
- □ Not Done/Normal CBE in Past 12 Months
- □ Not Done-Other/Unknown Reason
- □ Refused
- □ Skin dimpling or retraction

Paid for by WVBCCSP? □ Yes □ No

MOST RECENT PAP TEST

Facility That Performed Pap Test:

____

Date of Pap Test: _____ /_____ /_____

Paid for by WVBCCSP? □ Yes □ No

REMINDER: A copy of the Pap test report must be attached to this form.

INDICATIONS FOR COLPOSCOPY

- □ Visualized cervical lesion
  (even in absence of an abnormal Pap test)
- □ Pap test result of:
  - □ Adenocarcinoma
  - □ AIS
  - □ AGC
  - □ ASC-H
  - □ ASC-US (with a +, high-risk HPV test)
  - □ HSIL
  - □ LSIL
  - □ Squamous cell carcinoma

NOTICE TO PATIENT

I understand that I have met eligibility guidelines for the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP). I may have health insurance coverage and still be eligible for this referral to be paid for fully or partially by the WVBCCSP. My insurance will be billed first. I also understand that the Program will not cover pre-operative testing and certain other procedures that may be ordered. I will take this referral form to the physician or facility named above when I go to my appointment.

Patient Signature: ______________________________ Date: ______ /______ /______

Original: Physician Pink: WVBCCSP Yellow: Screening Provider Goldenrod: Patient

Send to: WVBCCSP 350 Capitol Street, Room 427, Charleston, WV 25301-3714
(304) 558-5388 or 1-800-642-8522