



Breast Health Clinic and Hereditary Cancer Risk Referral Form

Ph: 712-396-4117 Fax: 712-396-7944

Date: _____

Patient Name: _____ DOB: _____

Patient Phone Number: _____

Referring Provider: _____ Phone: _____ Fax: _____

Reason for Referral: _____

Please check the clinic you want the patient seen in: Breast Health Clinic Hereditary Cancer Risk Clinic

Patient aware of referral: Yes No Interpreter needed: Yes, language: _____ No

The referral will be scheduled once ALL of the following documents have been received:

- Completed Referral Form
 Recent Office Note with Health History, Medication Lists, etc.
 Demographics with Insurance cards
 All Breast images and reports including: Mammo, US, MRI, and/or Biopsy procedure for the last 2-3 years
 Pathology Report from Biopsy
Location of where biopsy was completed: _____
 Please include any additional scheduling comments (include any future scheduled test or pending results)
 If able, please provide patient a QR code to determine if patient meets criteria for genetic testing and/or increased risk.

BHC vs HCR Referrals

BHC

- Cancer/Biopsy path discussion
• Abnormal breast imaging
• Breast Pain/infection
• Breast lump

HCR

- Genetic Testing
• Family History
• Breast Density
• Increased lifetime risk of breast cancer

Thank you for your referral

Appointment Date/Time: _____

Our office will contact the patient to schedule. A confirmation fax will be sent with appointment information.

1st Attempt: _____ 2nd Attempt: _____ 3rd Attempt: _____

Referring Office Notified: _____ Faxed: _____ Date: _____

Questions? Please call: 712-396-4117

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Patient Label
NAME: _____ DOB: _____
FIN: _____ MRN: _____

PERMANENT PART OF MEDICAL RECORD