



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