Document Type: Orders/Referrals

DR0020

METHODIST JENNIE EDMUNDSON

Breast Health Clinic and Hereditary Cancer Risk Referral Form

Ph: 712-396-6326 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	HCR
• Cancer/Biopsy path discussion	• Genetic Testing
• Abnormal breast imaging	• Family History
• Breast Pain/infection	• Breast Density
• Breast lump	• 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: 712-396-6326

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD