MISSISSIPPI BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (MSBCCEDP)

570 East Woodrow Wilson PO Box 1700 Jackson, MS 39215-1700 601-576-7466

Breast Follow-Up Referral

Referral Date_____/_____/_____ Enrollment Site _____
mm dd yyyy Referring Provider_____

Patient's Name_____
Last First Middle Maiden

Phone Number (Day)_____ Phone Number (Alternate)_____

Address_____
Number and Street City State Zip

Date of Birth_____/_____/_____ Social Security Number_____
mm dd yyyy

Reason for Referral_____

Referred to (Clinic/Physician) _____ Phone Number_____

Appointment Date _____/_____/_____ Please send a copy of this form and report to MSBCCEDP address listed above or fax a copy to 601-576-8030.
mm dd yyyy

Physician Instructions: Please Check (√) All That Apply

Repeat CBE/Surgical Consult
- ☐ Normal/Benign
- ☐ Suspicious, Biopsy/FNA Recommended
- ☐ No Intervention Needed/Routine Follow-up
- ☐ Short Term Follow-up Recommended
- ☐ Refused/Not Done

Diagnostic Mammogram Results ACR BIRADS- (0, 1, 2, 3, 4, 5, 6)
- ☐ Negative (1)
- ☐ Benign (2)
- ☐ Probably Benign (3)
- ☐ Suspicious for cancer (4)
- ☐ Highly Suggestive (5)
- ☐ Known malignancy (6)
- ☐ Incomplete (0)
- ☐ Not Done

Ultrasound Results
- ☐ Negative
- ☐ Benign
- ☐ Probably Benign
- ☐ Suspicious, Biopsy/FNA Recommended
- ☐ Not Done

Fine Needle/Cyst Aspiration
- ☐ No Fluid/Tissue Obtained
- ☐ Not Suspicious for Cancer
- ☐ Suspicious for Cancer
- ☐ Not Done

Breast Biopsy Results
- ☐ Other Benign Changes
- ☐ Atypical Ductal Hyperplasia
- ☐ Invasive Cancer*
- ☐ Lobular Carcinoma In-Situ (LCIS)*
- ☐ Ductal Carcinoma In-Situ (DCIS)*
- ☐ Not Done/Refused
- ☐ Other_____

Status of Patient's Diagnostic Work-up
- ☐ Complete
- ☐ Pending
- ☐ Lost to Follow-up
- ☐ Refused

***Date of Diagnosis** _____/_____/_____
mm dd yyyy

***Please contact primary provider as soon as a diagnosis of cancer is known. Upon diagnosis, enrolled patient will be referred to Medicaid. The pathology report must be submitted to MSBCCEDP for Medicaid referral.**

Treatment Status**

☐ Treatment started, date_____/_____/_____ ☐ Pending ☐ Not Needed ☐ Refused
mm dd yyyy

****MSBCCEDP does not pay for treatment; however, the program will refer patients to the Mississippi Division of Medicaid for financial assistance.**

Please Check(√) Services Provided

☐ CPT_____	Office Visit	Date performed _____/_____/_____ mm dd yyyy
☐ CPT_____	Fine Needle Aspiration	Date Performed _____/_____/_____ mm dd yyyy
☐ CPT_____	Biopsy	Date Performed _____/_____/_____ mm dd yyyy
☐ CPT_____	Follow-up Office Visit	Date Performed _____/_____/_____ mm dd yyyy

Remarks_____

_____ _____ _____/_____/_____
Physician's signature License Number mm dd yyyy

Mississippi Breast and Cervical Cancer Early Detection Program

BREAST FOLLOW - UP REFERRAL FORM
FORM #717

PURPOSE

The purpose of this form is to provide written documentation for follow-up of abnormal mammograms, breast problems and biopsy results.

INSTRUCTIONS

This form is to be completed on all women screened through the Mississippi Breast and Cervical Cancer Early Detection Program requiring a referral for suspicious findings.

Date: Enter today's date using two-digit month, two-digit day and four-digit year.
Enrollment Site: Enter the site where the patient is being seen today by provider.
Referring Provider: Enter the provider's name who is sending the patient for procedure or test.

Patient Information Section: Must be completed in its entirety.
Patient's Name: Enter the last name, first name, middle and maiden if applicable.
Phone Number: Enter the daytime number and alternate number.
Address: Enter the number and street, city, state and zip code of where the patient is living when she presents to the facility.
Date of Birth: Enter patient's date of birth using two-digit month, two-digit day and four-digit month.
Social Security Number: Enter nine-digit number. If patient does not have SSN, enter 000-00-000 in this area. **DO NOT LEAVE BLANK.**
Reason for Referral: Enter the reason the patient is being referred to outside provider/facility.
Referred to (Clinic/Physician): Enter the name of the clinic/site or the referral provider.
Phone Number: Enter the telephone number of the clinic/referral provider.
Appointment Date: Enter the patient's appointment with the referral provider using two-digit month two-digit day and four-digit year.

The referral physician ONLY should complete the remainder of the form.

OFFICE MECHANICS AND FILING

The original form must be placed in the patient's record; a copy mailed or faxed to the referral provider; and a copy sent to the MS Breast and Cervical Cancer program.

RETENTION PERIOD

Retain according to agency policy for this type of patient retention schedule.

NOTE: Upon cancer diagnosis, the enrolled patient will be referred to The Division of Medicaid. The pathology report must be submitted to MSBCCEDP for Medicaid referral. MSBCCEDP does not pay for treatment; however, the patient may be referred for financial assistances through The Mississippi Division of Medicaid.