

**Breast and Cervical Cancer  
Prevention (BCCP) Clinic**

Fax 504.903.1605

Patient Label/Stamp

Referral from: BMC EKL LJC LAK  
LIH UMC WOM Other: \_\_\_\_\_

Attending Provider: \_\_\_\_\_ ID Number: \_\_\_\_\_

*If Label/Stamp is Not Available Complete the Following:*

Patient's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Record Number: \_\_\_\_\_

1° Contact Number: \_\_\_\_\_ 2° Contact Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Please Indicate Reason for Referral: Note information or workup needed for referral ( )**

- 793.80 Abnormal Finding on Mammogram (BiRAD 4 or 5) or Ultrasound **(1)**
- 782.2 Axillary Mass
- 611.0 Breast Abscess
- V76 Breast and Cervical Cancer Screening
- 610.1 Breast Biopsy: Atypical Ductal Hyperplasia **(1)**
- 233.0 Breast Biopsy: Ductal Carcinoma In Situ **(1)**
- 233.0 Breast Biopsy: Lobular Carcinoma In Situ **(1)**
- 174.9 Breast Cancer **(1)**
- V10.3 Breast Cancer previously treated **(2)**
- 611.72 Breast Mass **(3)**
- 611.79 Breast or Nipple Discharge: Bloody **(3)**
- 611.79 Breast or Nipple Discharge: not bloody; normal Prolactin, TSH, & T4; UPT Negative
- 611.71 Breast Pain: unresponsive to medical management with Anti-inflammatory drugs & Evening Primrose Oil, and with normal findings on Mammogram and Ultrasound testing
- V16 Family history of colon, melanoma, ovarian, pancreatic, or prostate cancer, or other hereditary cancer syndromes
- Other ICD: \_\_\_\_ Diagnosis: \_\_\_\_\_

**(1)Need reports and images for any previous studies (mammogram, ultrasound, MRI) and slides and reports of any biopsies if not performed at MCLNO.**

**(2)Need Records of Surgery/Chemo/Radiation Therapy if not performed at MCLNO**

**(3)Schedule Mammogram prior to clinic appointment**

Clinical History Relevant to this Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Referring Service/Clinic: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

**OFFICE USE ONLY:** Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_:\_\_ am/pm.

If not scheduled, Indicate Reason & Recommendation: \_\_\_\_\_  
\_\_\_\_\_

Reviewing Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Rev 02/19/09