

West Virginia Breast and Cervical Cancer Screening Program Referral Form

All results plus the Radiology or Cervical Diagnostic Reports must be mailed to the screening provider and a copy must be forwarded with the invoice to the WVBCSP. See bottom of form for the WVBCSP address.

Screening Facility: _____ BCCSP#: _____

Screening Clinician: _____ Date referred: ____/____/____

Telephone: (____) _____

Client Name (Last, First, MI): _____ DOB: ____/____/____ Social Security #: ____-____-____

Provider Receiving Referral

Referral Provider: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Date Appointment: ____/____/____ Time: _____

Breast Referral for:

Cervical Referral for:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Screening mammogram bilateral | <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Colposcopy with loop electrode biopsy |
| <input type="checkbox"/> Screening mammogram unilateral | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Colposcopy with biopsy | <input type="checkbox"/> Endocervical curettage (not done as part of D&C) |
| <input type="checkbox"/> Diagnostic mammogram bilateral | | <input type="checkbox"/> Loop electrode excision procedure (LEEP) of cervix | <input type="checkbox"/> Conization of cervix with or without repair |
| <input type="checkbox"/> Diagnostic mammogram unilateral | | <input type="checkbox"/> Colposcopy with biopsy and endocervical curettage | <input type="checkbox"/> Endometrial biopsy in conjunction with colposcopy |
| <input type="checkbox"/> Surgical Consultation | | <input type="checkbox"/> Colposcopy with endometrial curettage | |
| <input type="checkbox"/> Fine needle aspiration | | <input type="checkbox"/> Colposcopy with loop electrode conization of the cervix | |
| <input type="checkbox"/> Puncture aspiration of cyst | | <input type="checkbox"/> Cervical biopsy or local excision of lesion | |

Mammogram performed: Yes ☐ No ☐ Date of Mammogram: ____/____/____

*Ultrasound is reimbursed when performed within one month of mammography.

*Reimbursement is limited to CPT codes in the BCCSP Fee Schedule.

CBE result

Most recent Pap Test

Indication for Colposcopy

Date Performed: ____/____/____

Date Performed: ____/____/____

☐ Visualized cervical lesion

☐ Benign finding

Facility that performed test: _____

Pap test result:

☐ Bloody/Serous Nipple Discharge

☐ Adenocarcinoma ☐ Squamous cell carcinoma

☐ Discrete Palpable mass

☐ AIS ☐ LSIL

☐ Skin dimpling/ Retraction

☐ AGC ☐ HSIL

☐ Nipple/Areolar scaliness

☐ ASC-H ☐ ASC-US (with a +, high-risk HPV test)

☐ Focal pain and tenderness

☐ Normal Exam

☐ Not done/Normal CBE in past 12 months

* A copy of the test report must be attached to this form.

☐ Not done – other/Unknown reason

☐ Refused

Paid for by WVBCSP ☐ Yes ☐ NO

I understand that I have met the eligibility guidelines for the West Virginia Breast and Cervical Cancer Screening Program (WVBCSP). I may have health insurance and still be eligible for this referral to be paid for fully or partially by the WVBCSP. My insurance will be billed first. I also understand that the program will not cover pre-operative testing and certain other procedures that may be ordered. I will take this referral form to the physician or facility named above when I go to my appointment.

Patient Signature: _____ Date: ____/____/____

Original: Physician

Copy: WVBCSP

Copy: Screening Provider

Copy: Patient

WVBCSP Form # Y202 Rev. 04/2025

Send to WVBCSP 350 capitol street, Room 427, Charleston WV 25301

Tel: (304) 558-5388 or 1-800-642-8522