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 WVBCCSP. See bottom of form for the WVBCCSP address.

Screening Facility: _____ **BCCSP#:** _____

Screening Clinician: _____ **Date referred:** _____/_____/_____

Telephone: (_____) _____

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

Provider To whom Referred

Referral Provider: _____

Address: _____

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

Date Appointment: _____/_____ /_____ **Time:** _____

Breast Referral for:

- ☐ Screening mammogram bilateral
- ☐ Screening mammogram unilateral
- ☐ Diagnostic mammogram bilateral
- ☐ Diagnostic mammogram unilateral
- ☐ Surgical Consultation
- ☐ Fine needle aspiration
- ☐ Puncture aspiration of cyst
- ☐ Breast Biopsy
- ☐ Ultrasound

Cervical Referral for:

- ☐ Colposcopy
- ☐ Colposcopy with biopsy
- ☐ Loop electrode excision procedure (LEEP) of cervix
- ☐ Colposcopy with biopsy and endocervical curettage
- ☐ Colposcopy with endometrial curettage
- ☐ Colposcopy with loop electrode conization of the cervix
- ☐ Cervical biopsy or local excision of lesion
- ☐ Colposcopy with loop electrode biopsy
- ☐ Endocervical curettage (not done as part of D&C)
- ☐ Conization of cervix with or without repair
- ☐ Endometrial biopsy in conjunction with colposcopy

Mammogram performed: ☐ **Yes** ☐ **No** **Date of Mammogram:** _____ /_____ /_____

*Ultrasound is reimbursement when performed within one month of mammography. *Reimbursement rendered for approved CPT codes ONLY.

CBE result

Date Performed: ____/____ /_____

- ☐ Benign finding
- ☐ Bloody/Serous Nipple Discharge
- ☐ Discrete Palpable mass
- ☐ Skin dimpling/ Retraction
- ☐ Nipple/Areolar scaliness
- ☐ Normal Exam
- ☐ Not done/Normal CBE in past 12 months
- ☐ Not done – other/Unknown reason
- ☐ Refused

Paid for by WVBCCSP ☐ **Yes** ☐ **NO**

Most recent Pap Test

Date Performed: _____ /_____ /_____

Facility that performed test: _____

_____

Paid for by WVBCCSP? ☐ **Yes** ☐ **NO**

Indication for Colposcopy

- ☐ **Visualized cervical lesion**

Pap test result:

- ☐ Adenocarcinoma
- ☐ AIS
- ☐ AGC
- ☐ ASC-H
- ☐ Squamous cell carcinoma
- ☐ LSIL
- ☐ HSIL
- ☐ ASC-US (with a +, high-risk HPV test)

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

I understand that I have met the eligibility guidelines for the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP). I may have health insurance and still be eligible for this referral to be paid for fully or partially by the WVBCCSP. 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: WVBCCSP Copy: Screening Provider Copy: Patient WVBCCSP Form # Y202 Rev. 12/2023

Send to WVBCCSP 350 capitol street, Room 427, Charleston VW 25301 Tel: (304) 558-5388 or 1-800-642-8522