REQUEST FOR BREAST CARE SERVICES

NASH BREAST CARE CENTER, 250 Medical Arts Mall, Rocky Mount, NC 27804
Phone: (252) 962-6100

NASH UNC HEALTH CARE

Please Complete and FAX this Form to: (252) 962-6115

Please attach any relevant physician notes, diagnostic test results, and breast imaging reports.

Provider Information

Referring Provider: _____
UPIN #: _____
Referring Physician Office: _____
Phone Number: _____
Fax Number: _____

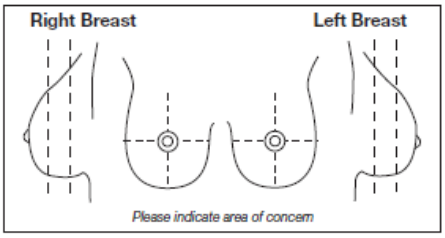
Provisional Diagnosis (Please mark all that apply):

- ☐ Annual/Screening Exam, No Symptoms (Z12.31)
- ☐ Personal History of Breast Cancer (Z85.3)
- ☐ Family History of Breast Cancer (Z80.3)
- ☐ High/Genetic Risk for Breast Cancer (Z15.01)
- ☐ Breast Lump/Mass (N63) ⟶ ☐Right ☐Left
- ☐ Breast Pain (N64.4) ⟶ ☐Right ☐Left
- ☐ Nipple Discharge (N64.52) ⟶ ☐Right ☐Left
- ☐ Calcifications (R92.0/R92.1) ⟶ ☐Right ☐Left
- ☐ Other: _____

Patient Information

Patient Full Name: _____
Patient Phone Number(s): _____
Date of Birth: _____
Social Security #: _____ **Nash MR #:** _____
Patient Address: _____
City, State, Zip: _____

☐ **Insured** ☐ **Self-Pay** ☐ **Other** _____



If patient's last mammogram was not taken at our facility, please have patient sign the 'Authorization for Disclosure of Health Information' form and include with faxed order.

☐ **Comprehensive Breast Care Referral** – Beginning with the specific imaging studies requested below, this comprehensive referral authorizes Nash Breast Care Center to schedule additional imaging or procedures for the patient on behalf of the referring provider, if needed, to expedite diagnosis and to improve efficiency of patient care. Referring provider will be notified if further procedures are needed, but additional orders will not be required.

- **Screening Mammogram with 3D/Tomosynthesis** (CPT G0202+77063) ☐ **Right** ☐ **Left** ☐ **Bilateral**
- **Diagnostic Mammogram** ☐ **Right** (CPT G0206) ☐ **Left** (CPT G0206) ☐ **Bilateral** (CPT G0204)
- **Limited Breast Ultrasound (1 or more areas) w/ Axilla** (CPT 76642) ☐ **Right** ☐ **Left**
- **Complete (4 quadrant Breast Ultrasound w/ Axilla)** (CPT 76641) ☐ **Right** ☐ **Left**
- **Axillary Ultrasound** (CPT 76881-limited/76882-complete)
- **Axillary Ultrasound Biospy** (CPT 38505)
- **Ultrasound Core Biopsy** (CPT 19083)
- **Stereotactic Core Biopsy** (CPT 19081)
- **Cyst Aspiration** (CPT 19000)

☐ **Individual Breast Care Referral –** Only the individual selected exams will be performed.

- ☐ **Screening Mammogram (with 3D/Tomosynthesis)** (CPT G0202+77063) ☐ **Right** ☐ **Left** ☐ **Bilateral**
- ☐ **Diagnostic Mammogram** ☐ **Right** (CPT G0206) ☐ **Left** (CPT G0206) ☐ **Bilateral** (CPT G0204)
- ☐ **Limited Breast Ultrasound (1 or more areas) w/ Axilla** (CPT 76642) ☐ **Right** ☐ **Left**
- ☐ **Complete Breast Ultrasound (4 quadrant scan) w/ Axilla** (CPT 76641) ☐ **Right** ☐ **Left**
- ☐ **Axillary Ultrasound** (CPT 76881-limited/76882-complete)
- ☐ **Ultrasound Core Biopsy** (CPT 19083)
- ☐ **Axillary Ultrasound Biopsy** (CPT 38505)
- ☐ **Stereotactic Core Biopsy** (CPT 19081)
- ☐ **Cyst Aspiration** (CPT 19000)

P03005

☐ **Bone Density –** Axial Skeleton (most commonly used) (CPT 77080)
☐ **Bone Density –** Appendicular Skeleton (CPT 77081) ☐ **Right** ☐ **Left** ☐ **Bilateral**

Referring Provider Signature: _____ **Date:** _____

- It is the patient's responsibility to contact the insurance company prior to the scheduled test date to check coverage.
- This order is good for 12-months from the date/time of physician signature.
- Please ask patient to bring photo ID and insurance card(s) to appointment.

Revised 6/2017