

Take Charge! Screening and Diagnostic Services Coupon ODH Form No. 1342

Part 1: DEMOGRAPHICS

Clinic name:	Clinic site number:	Social security number:	Age:
Last name:	First name:	MI:	Maiden:
DOB: / /	Daytime phone number: () -	Evening phone number: () -	
Address:	City:	State:	Zip:
Is patient pregnant: <input type="checkbox"/> Yes	Due date of pregnancy: / /	<input type="checkbox"/> No	Meets Income Guidelines: <input type="checkbox"/> Yes <input type="checkbox"/> No
Interpreter needed?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Translation type: <input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:
Race: <input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaskan Native	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

Part 2: CURRENT BREAST AND/OR CERVICAL FINDINGS

Procedure	Findings	Location	Date	Duration of Symptoms
			/ /	
			/ /	

Part 3: PREVIOUS BREAST AND/OR CERVICAL DIAGNOSTIC PROCEDURES

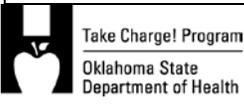
Procedure	Diagnosis	Date	Facility Name
		/ /	
		/ /	

Part 4: SERVICE REQUESTED

Breast Services	Cervical Services
<input type="checkbox"/> Screening Mammogram (initial or routine)	<input type="checkbox"/> LEEP
<input type="checkbox"/> Diagnostic Mammogram (check reason below) ___ Left breast ___ Right breast <input type="checkbox"/> Abnormal Finding <input type="checkbox"/> Implants <input type="checkbox"/> Follow-up Mammogram	<input type="checkbox"/> Colposcopy
	<input type="checkbox"/> Colposcopy with Biopsy
	<input type="checkbox"/> Cervical Specialist Consultation
<input type="checkbox"/> Breast Ultrasound ___ Left breast ___ Right breast	<input type="checkbox"/> Short Term Follow-Up Office Visit or Post Treatment Office Visit
<input type="checkbox"/> Ultrasound or Stereotactic Guided Breast Biopsy	Additional breast and/or cervical clinical comments:
<input type="checkbox"/> Screening MRI ___ Left breast ___ Right breast	
<input type="checkbox"/> Fine Needle Aspiration (with/without imaging guidance)	
<input type="checkbox"/> Breast Specialist Consult (Films and records must be sent to appointment.)	

Part 5: APPOINTMENT INFORMATION	Part 6: REFFERAL INFORMATION
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A <u>CURRENT</u> Take Charge! eligibility letter and <u>this Coupon</u> must be presented at the time of the patient's appointment.	
Date: / /	Time: / /
Name of facility:	Name of referring provider:
Phone number of facility: () -	Referring provider phone number: () -
Address of facility:	Referring provider fax number: () -
Additional appointment instructions:	Referring provider address:
	Issue date: ___/___/___ Expiration date: ___/___/___ (60 days after issued date)
	Send report by: <input type="checkbox"/> Fax <input type="checkbox"/> Mail



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