Take Charge! Screening and Diagnostic Services Coupon

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 client pregnant: Yes ☐ Due date of pregnancy ____/____/____ No ☐ Meets income guidelines: Yes ☐ No ☐

Interpreter needed?: Yes ☐ No ☐ Translation type: Spanish ☐ Chinese ☐ Vietnamese ☐ Other:_____

Race: White ☐ Black ☐ Asian ☐ American Indian ☐ Native Hawaiian ☐ Pacific Islander ☐ Eskimos ☐ Other ☐ Unknown ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Unknown ☐

Part 2: CURRENT BREAST AND/OR CERVICAL FINDINGS

Findings	Location	Date/Duration

Part 3: PREVIOUS BREAST AND/OR CERVICAL DIAGNOSTIC PROCEDURES

Procedure	Diagnosis	Date	Facility Name

Part 4: SERVICE REQUESTED

Breast Services	Cervical Services
☐ Screening Mammogram (initial or routine)	☐ LEEP
☐ Diagnostic Mammogram (check reason below) ____ Left breast ____ Right breast ☐ Abnormal Finding ☐ Implants ☐ Follow-up Mammogram	☐ Colposcopy ☐ Colposcopy with Pap test ☐ Cervical Specialist Consult
☐ Breast Ultrasound ____ Left breast ____ Right breast	☐ Short Term Follow-Up Office Visit or Post Treatment Office Visit
☐ Ultrasound or Stereotactic Guided Breast Biopsy	Additional breast or cervical clinical comments:
☐ Fine Needle Aspiration (with or without imaging guidance)	
☐ Breast Specialist Consult (films and records must be sent to appointment)	

Part 5: APPOINTMENT INFORMATION

Date: ____/____/____ Time:

Name of facility:

Phone number of facility: ( ) -

Address of facility:

Additional appointment instructions:

Part 6: REFFERAL INFORMATION

Name of referring provider:

Referring provider phone number: ( ) -

Referring provider fax number: ( ) -

Referring provider address:

Issue date: ___/___/___ Expiration date: ___/___/___
(60 days after issue date)

Send report by: ☐ Fax ☐ Mail

SAMPLE