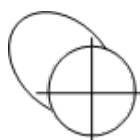


Local Health Dept. _____

1. Breast symptoms (self-identified): ☐ Yes ☐ No ☐ Unknown
2. Previous MAMMOGRAM: ☐ Yes ☐ No ☐ Unknown
If Yes, approximate Month/Year ____/____
Where? _____
3. Previous breast MRI: ☐ Yes ☐ No ☐ Unknown
If Yes, approximate Month/Year ____/____
Where? _____
4. Previous breast ULTRASOUND (u/s): ☐ Yes ☐ No ☐ Unknown
If Yes, approximate Month/Year ____/____
Where? _____
5. Previous breast BIOPSY: ☐ Yes ☐ No ☐ Unknown
If Yes, approximate Month/Year ____/____

Site

Right



Left



6. Patient had breast cancer ☐ Yes ☐ No ☐ Unknown
If Yes, approximate Month/Year ____/____

7. Assessed as high-risk for breast cancer? ☐ Yes ☐ No
8. Breast Implants? ☐ Yes ☐ No
9. Clinical Breast Exam (CBE) results:
☐ Normal/Nodularity
☐ Fibrocystic or Other Benign Findings (explain) _____

☐ **Discrete Lump or Mass**
☐ **Discharge (e.g., clear, serous, bloody)**
☐ **Nipple or Areolar Scaling**
☐ **Skin Dimpling, Retraction**
☐ **Focal, Immobile Thickening**

Results in **BOLD** require diagnostic referral

Site:

Right



Left



10. This order is for (choose only ONE per form):
☐ Mammogram ☐ Breast MRI ☐ Breast u/s
11. Type of mammogram, breast MRI, breast u/s:
☐ Screening ☐ Initial Diagnostic ☐ Follow-up Diagnostic

Visit Date

CBE Provider Signature

Provider ID

SURGEON information for any needed follow-up (under LHD contractual agreement) or PMD

Name: _____

Phone: _____

Address: _____

Zip: _____

PATIENT: I have been informed and understand that I'm being referred to Radiology Service Provider: _____
for a mammogram, breast MRI, or breast ultrasound (indicated above). The results will be reported to this health department, and depending
on my income, I may be responsible for paying a portion of the charge(s) for the service(s).

Patient Signature and Date: _____

TO BE COMPLETED BY THE IMAGING SERVICE PROVIDER:

12. Which imaging was performed? ☐ Mammogram ☐ Breast MRI ☐ Breast u/s
13. Which type of mammogram, breast MRI, breast u/s was performed for this report? ☐ Screening ☐ Initial Diagnostic ☐ Follow-up Diagnostic
14. Mammogram / breast MRI results/ breast ultrasound results: **(CIRCLE ONE)**

0 = Assessment is Incomplete

* Prior Film Comparison Required? ☐ Yes ☐ No

1 = Negative

2 = Benign Finding

3 = Probably Benign

4 = Suspicious Abnormality

5 = Highly Suggestive of Malignancy

6 = Known Biopsy-Proven Malignancy

U = Technically Unsatisfactory (**not a BI-RADS**) - image could not be read by radiologist

**Source-American College of Radiology BI-RADS*

Describe abnormal findings and recommendations for follow-up care: _____

____/____/____
Date of Imaging

X _____
Radiologist Signature

Name and address of agency storing mammography films: _____

INSTRUCTIONS FOR THE WH-16 / BREAST CANCER SCREENING REPORT

The **WH-16**, previously known as the ACH-16, has not changed its' intent, and is used to request and document results of mammograms, breast MRIs, and breast ultrasounds from the radiology provider. The mammogram/MRI/ultrasound narrative report should be kept with the completed WH-16 and filed together in the medical record. The WH-16 should be filled out on all women being referred for a mammogram/breast MRI/breast ultrasound regardless of income, age, or payer status.

TO BE COMPLETED BY LHD

1. Enter the name of the LHD requesting the mammogram/breast MRI/breast ultrasound.
2. Attach a lab label in the place provided.
3. Complete items 1–8 with information from the current history.
4. Enter the results of the clinical breast examination in item 9.
5. In item 10, specify if this order is for a mammogram, breast MRI, or breast ultrasound. (Enter only 1 per form.) If more than one is ordered, use a separate WH-16 form for each.
6. In item 11, enter the type of mammogram/breast MRI/breast ultrasound requested.
7. Next, enter the visit date, and the signature and identification number of the clinical breast examination provider.
8. Finally, enter the name, address, and telephone number of the contracted surgeon who will be evaluating abnormal test results (or patient's PMD).

TO BE SIGNED BY THE PATIENT

1. Have the patient sign the referral section.
2. Retain the copy of the form in a tickler file at the LHD to track receipt of themammogram/MRI results. The form should be sent to the radiology facility.
3. If desired by the patient, have a release of information (ROI) signed so a copy of themammogram result can be sent to the patient's family physician.

TO BE COMPLETED BY MAMMOGRAPHY PROVIDER

1. Check whether a mammogram, breast MRI, or breast ultrasound was performed in item 12.
2. In item 13, choose which type of mammogram/breast MRI/breast ultrasound was performed. (e.g. If a screening mammogram is requested in item 11, a screening mammogram should be performed; if the LHD requests a diagnostic mammogram in item 11, an initial diagnostic mammogram should be performed; when a screening mammogram has been requested and performed and the radiologist has determined the need for additional views, a separate WH-16 should be initiated and Follow-up Diagnostic checked in item 13.
3. The applicable BI-RAD category is entered by the radiologist in item 14. Include a description of any negative findings, the date of the mammogram/MRI/ultrasound and the signature of the radiologist.
4. Enter the name and address of the agency storing the mammography films.
5. The mammography provider keeps a copy of the form.
6. A copy of the completed WH-16 is returned to the LHD.

A LHD nurse shall note results and the patient shall be notified. A copy of the form shall be filed in the medical record with the narrative report attached to it.