


Local Health Dept. \_\_\_\_\_

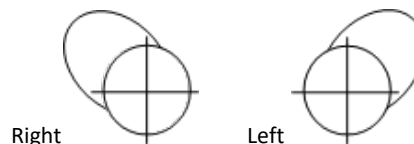
1. Breast symptoms (self-identified):  Yes  No  Unknown
2. Previous MAMMOGRAM:  Yes  No  Unknown  
If Yes, approximate Month/Year \_\_\_\_/\_\_\_\_  
Where? \_\_\_\_\_
3. Previous breast MRI:  Yes  No  Unknown  
If Yes, approximate Month/Year \_\_\_\_/\_\_\_\_  
Where? \_\_\_\_\_
4. Previous breast ULTRASOUND (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

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:



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

**4** = Suspicious Abnormality

**1** = Negative

**5** = Highly Suggestive of Malignancy

**2** = Benign Finding

**6** = Known Biopsy-Proven Malignancy

**3** = Probably Benign

**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: \_\_\_\_\_

Label here from  
Patient Services Reporting System

## WH-16 (previously known as ACH-16) Breast Cancer Screening Form

### 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.**