



# Breast and Cervical Cancer Early Detection Program (BCCP) FY25 BCCP Screening/Referral Form: July 2024 – June 2025

*[FORM VALID FOR SCREENING AND REFERRALS/ORDERS FOR 12 MONTHS FROM DATE ENROLLED AND EXTENDS THROUGH THE END OF MONTH IT EXPIRES. FOR POSSIBLE SHORT-TERM EXTENSION, CONTACT THE BCC PROGRAM.]*

**SCREENING CLINIC:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_

**CLIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**BCCP ENROLLMENT DATE:** \_\_\_\_\_ **DATE ENROLLMENT EXPIRES:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ENROLLMENT DATE CORRESPONDS TO DATE BCCP ELIGIBILITY AND CONSENT FORM SIGNED.** **INSURANCE STATUS:**  Uninsured (refer to <https://www.BeWellNM.com>)  Underinsured (screening and/or diagnostic services not included in plan)

**Hispanic/Latino Origin:**  Yes  No (Please identify Hispanic/Latino Origin AND one or more of the races listed below.)

**Race (check all that apply):**  American Indian/Alaska Native  Asian  Black/African American  Native Hawaiian/Pacific Islander  White  Other: \_\_\_\_\_

**Preferred Language:**  English  Spanish  Navajo  American Sign Language  Other American Indian  Other: \_\_\_\_\_

**Smoking Status:**  Never  Former  Current >>> Referred to cessation services (e.g., 1-800-QUITNOW or [www.quitnownm.com](http://www.quitnownm.com))?  No  Yes (includes all cessation services)

**BREAST SECTION: For people already known to be at high risk for breast cancer, documentation of high-risk status is required when requesting prior authorization for high-risk breast cancer screening. Those with no personal history of breast cancer should undergo risk assessment to determine their breast cancer risk and guide appropriate screening.**

1. Breast cancer risk status: info at BCCP website: <https://www.nmhealth.org/about/phd/pchb/bcc/>  
 Personal history of breast cancer: no risk assessment is required, and appropriate surveillance guideline should be followed.  
**High** If one or more of the items below are true, no further risk assessment is required, and appropriate high-risk screening recommendation should be followed.  
 PRE-menopausal breast cancer among first-degree relative(s)  
 Known genetic mutation such as BRCA 1 or 2 (the person/client or first-degree relative)  
 Had radiation treatment to chest between ages 10-30 years  
 History of lobular neoplasia (LCIS), atypical lobular hyperplasia (ALH), ductal carcinoma in situ (DCIS), or atypical ductal hyperplasia (ADH)  
 Personal or family history of certain genetic syndromes (e.g., Li-Fraumeni)  
 If none of the items above are true, complete a breast cancer risk assessment tool to calculate the person's/client's lifetime risk for developing breast cancer.  
 Calculated lifetime risk of 20% or more for developing breast cancer based on risk assessment model: **LIFETIME RISK = \_\_\_\_\_% [enter percentage]**

**Average** per risk assessment model; breast cancer risk status should be reassessed periodically (e.g., during enrollment) because average risk status may change over time.

Unknown >> REASON: \_\_\_\_\_

2. Currently lactating (breastfeeding)?  No  Yes

3. Breast symptoms reported by client?  No  Yes\* >> How Long? \_\_\_\_\_  
If yes, describe: \_\_\_\_\_

\*Clinical breast exam (CBE) may be performed per clinician preference, but when there are symptoms, a CBE is required to guide potential referral for diagnostic services.

**CURRENT CLINICAL BREAST EXAM (CBE) RESULTS/INFORMATION:**

CBE Date: \_\_\_\_\_

Normal/Benign (includes fibrocystic changes)  Not needed  Declined

Is today's exam a short-term follow-up CBE to a previous abnormal CBE?

No  Yes >>> Date of previous abnormal CBE: \_\_\_\_\_

**MARK POSITIVE FINDINGS BELOW AND CLICK ON BREAST DIAGRAM TO SHOW LOCATION AND SIZE.**

If symptomatic or positive findings, follow current NCCN Guidelines® (<http://www.nccn.org/>)\*\*

Palpable mass  
 Nipple discharge:  Unilateral  Bilateral  
 • Spontaneous?  No  Yes  
 • Expressed on exam?  No  Yes  
 • If yes: Color? \_\_\_\_\_  
 Bloody?  No  Yes  
 Single Duct?  No  Yes  
 Asymmetrical thickening or nodularity  
 Skin changes (peau d'orange, erythema, nipple excoriation, scaling, eczema, skin ulcers)

**\*\* Although NCCN Guidelines® may recommend diagnostic evaluation and follow-up for those under age 30, the BCC Program cannot reimburse for these services for average risk people.**

**PRIOR AUTHORIZATION (PA) REQUIRED FOR: HIGH RISK BREAST CANCER SCREENING (I.E., SCREENING BREAST MRI), BREAST WORK-UP IF AGE 30-39 YEARS, DIAGNOSTIC MRI, MAMMARY DUCTOGRAM, CHEST WALL BIOPSY, AXILLARY LYMPH NODE BIOPSY.** PA Date: \_\_\_\_\_ Approved by: \_\_\_\_\_ at BCC.

**CERVICAL SECTION: All individuals must be assessed for their cervical cancer risk using the criteria in #1 below to guide appropriate screening.**

1. Cervical cancer risk status: info at BCCP website: <https://www.nmhealth.org/about/phd/pchb/bcc/>  
 High (history of cervical cancer, had *in utero* DES exposure, and/or is immunocompromised (e.g., HIV positive))  
 Above Average (patient has history of CIN2 or greater but does not meet "high" risk criteria above)  
 Average  
 Unknown >> REASON: \_\_\_\_\_

2. Ever had a Pap test before today?  No  Yes >>> Date of last Pap test: \_\_\_\_\_  
(IF UNSURE OF DATE, MUST PROVIDE BEST GUESS FOR MONTH AND YEAR OF LAST PAP)

3. Pregnant now?  No  Yes >>> estimated due date: \_\_\_\_\_

4. Hysterectomy?  No  Yes >>> hysterectomy for cervical cancer?  No  Yes

5. Intact cervix?  No  Yes

Current USPSTF cervical cancer screening recommendations for average risk women with normal results are: screening with Pap test alone every 3 years for ages 21-65 years; or, for ages 30-65 years, screening with high-risk HPV test alone (primary HPV testing) every 5 years, or screening with both a Pap test and HPV test together (co-testing) every 5 years.

**CURRENT CERVICAL EXAM RESULTS/INFORMATION: If Pap and/or HPV test done, must attach copy of cytology report with claim to request reimbursement.**

Pap test done today?  No  Yes >>> Pap Test Date: \_\_\_\_\_

If yes, is today's Pap test to follow-up a previous abnormal Pap test?

No  Yes >>> Date of previous abnormal Pap test: \_\_\_\_\_

If Pap test not done today, complete reason(s) below:

Not needed  Done recently elsewhere  Declined  Needed, not performed >>>

Initiate cervical cancer screening reminder in electronic medical record.

HPV test done today?  No  Yes >>> HPV Test Date: \_\_\_\_\_

If HPV test done today, complete reason for test below:

Co-test (in combination with screening Pap test)  
 Primary Screening  
 Reflex (follow-up after abnormal screening Pap test)

**PRIOR AUTHORIZATION (PA) REQUIRED FOR: CERVICAL DIAGNOSTIC EXCISIONAL PROCEDURES (I.E., LEEP, COLD-KNIFE CONIZATION), FURTHER EVALUATION OF VISIBLE CERVICAL LESIONS WHEN PAP TEST RESULT IS NORMAL, AND POST CERVICAL CANCER SURVEILLANCE.** PA Date: \_\_\_\_\_ Approved by: \_\_\_\_\_ at BCC.

Was client enrolled in the BCCP and referred for diagnostic services only?  No  Yes >>> Date of referral: \_\_\_\_\_ *ENROLLMENT DATE CORRESPONDS TO DATE BCCP ELIGIBILITY AND CONSENT FORM SIGNED.*

**REFERRAL/ORDERS: Use the space below to complete referral/orders for additional breast and/or cervical cancer screening and/or diagnostic services within the BCCP Provider Network.**

Please bring this form to your appointment(s) listed below. Por favor traiga esta forma a la(s) cita(s) mencionada(s) debajo.

Referral/Order for: \_\_\_\_\_ Appointment date: \_\_\_\_\_  
 Time: \_\_\_\_\_ Facility: \_\_\_\_\_ Doctor: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referencia/Orden para: \_\_\_\_\_ Fecha de la cita: \_\_\_\_\_  
 Hora: \_\_\_\_\_ Clínica: \_\_\_\_\_ Médico: \_\_\_\_\_  
 Dirección: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Referral/Order for: \_\_\_\_\_ Appointment date: \_\_\_\_\_  
 Time: \_\_\_\_\_ Facility: \_\_\_\_\_ Doctor: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referencia/Orden para: \_\_\_\_\_ Fecha de la cita: \_\_\_\_\_  
 Hora: \_\_\_\_\_ Clínica: \_\_\_\_\_ Médico: \_\_\_\_\_  
 Dirección: \_\_\_\_\_ Teléfono: \_\_\_\_\_