MAMMOGRAM SCREENING ACCESS PROGRAM

PROVIDED BY: Moffitt Cancer Center

REQUEST FORM

Referral Date: _____ (Request Valid for 90 days from referral date)

Patient Name: _____ DOB: _____

Patient Address: _____

Zip Code: _____ Patient Phone Number: _____

Preferred Language: _____ Marital Status: _____

Name of Referring Clinic: _____

Name of Referring Provider: _____

Clinic or Provider Phone Number: _____

To qualify, the patient must be:

- ☐ 40 – 64 years of age
- ☐ **OR** 30 – 39 years of age (w/ strong family history of breast ca)
- ☐ **OR** 30 – 39 other breast cancer risk factor(s)

  Please indicate risk factor(s) _____

And meet ALL of the criteria below:

- ☐ Must not have health insurance or be eligible for Medicaid/Medicare or HCHCP
- ☐ Meet income guideline (<200% of FPL)
- ☐ Not be on tourist visa
- ☐ Live in Hillsborough county

If the patient meets ALL of the above criteria, please follow the instructions below and inform your patient of the expectations for the screening procedure.

1. Fax this form, recent clinic notes and patient demographics to **813-449-8210**
2. Once the faxed information has been reviewed and approved, our team will contact the patient to schedule the procedure. The patient must be responsible for **returning phone calls within 48 hours** and arranging their appointment.
3. A referral and prior mammogram imaging CD are required
4. Patients needing a Diagnostic mammogram due to breast symptoms must provide prior imaging records, office notes and have a diagnostic mammogram and breast us referral

Thank you for referring our patient to Moffitt Cancer Center.

Please email any questions to FCUFinancialCounselors@Moffitt.org.

Patient, please bring this form with you to your appointment. *Por favor traigan este formulario a su cita.*

MOFFITT CANCER CENTER