



Best Chance Network Case Management Intake Form

(Please fax referral and reports to SC DHEC BCN PA Line 1-866-297-6814)

Last Name: _____ First Name: _____ MI: _____
 Address: _____ City: _____ State: _____ Zip: _____ County: _____
 Last 4 Digits of SSN#: _____ Patient's Home Phone #: _____
 Patient's Work Phone #: _____
 DOB: _____ Race: _____ Marital Status: _____

Referral Source: **BCN** Referring Facility: _____
 Referred by: _____ Phone #: _____
(Person making referral)
 Patient notified of test results: Yes No Provider Name: _____

Emergency Contact: Name: _____
 Relationship to Client: _____ Home Phone #: _____ Cell Phone #: _____

Test Results - Please fax reports with referral	Result Date
1. Mammogram or MRI - ACR BI-RADS Category 4 (Suspicious)	
2. Mammogram or MRI - ACR BI-RADS Category 5 (Highly Suggestive of Malignancy)	
3. Breast Ultrasound - ACR BI-RADS Category 4 or 5, Solid Mass	
4. Pap Smear - Atypical Glandular Cells (AGC)	
5. Pap Smear - Low-Grade Squamous Intraepithelial Lesion (If HPV is negative, repeat co-testing in 12 months preferred.)	
6. Pap Smear - High-Grade SIL (HGSIL)	
7. Pap Smear - Squamous Cells of Carcinoma/Adenocarcinoma	
8. Pap Smear - Atypical Squamous Cells of Undetermined Significance - cannot exclude High-Grade SIL (ASC-H)	
9. Positive HPV DNA Test. (If ASCUS Pap or if this is second consecutive Negative Pap and HPV positive result.)	
10. Pelvic Exam - Suspicious for Cervical Cancer	

No Barriers Identified
Client Barriers:
 Financial Language Transportation
 Knowledge Support Other _____

Additional Client Information:
 Missed Follow-Up Appt. Refused Referral Unable to Contact
 Follow-up Referral Facility: _____ Phone #: _____
 Purpose of Follow-up Referral: _____ Date and Time of Appointment: _____

Comments:

DHEC staff taking referral: _____ Date: _____

**Instructions for Completing the
Best Chance Network
Case Management Intake Form
DHEC 3714**

Purpose: Case management referrals to BCN are no longer required if your facility has its own process for following up on clients with abnormal screening results. You may refer your clients to BCN case management if they need additional support to obtain necessary services.

This form is to be used as an intake form for the BCN staff in order to complete a referral for BCN case management services. Use the form for identifying the reason for the referral and to supply supportive and identifying information.

Instructions:

In the first box, complete the identifying data for the BCN client being referred.

In the second box, complete the blank for the referring facility (physician's office), enter the name of the person faxing in the referral form and the phone number where you can be reached.

In the third box, complete the remaining identifying information as requested.

Test Results: Select the appropriate diagnosis and enter the date the test was completed.

Client Barriers: Check all boxes that apply to your client.

Mark the appropriate box under Additional Client Information.

Follow-up Referral: Write the name of the follow-up referral facility and phone number. Provide the purpose for the follow-up referral and the date and time of the appointment.

Comments: Give additional information that might help in providing services for the client.

Person Receiving Referral: The appropriate BCN staff receiving the referral needs to sign his/her name. All referrals must be signed by the staff who receives and processes the referral.

Date: Put the date that the referral was received and faxed to the case manager.

Office Mechanics and Filing: BCN provider maintains a copy in the client record. DHEC BCN scans the original, uploads to the database, and shreds original per Agency protocol.