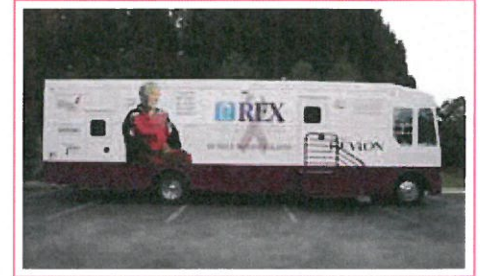
REX Mobile Mammography Patient Instructions

All patients must present a photo id and insurance card, if applicable, and be pre-registered. Please fax all legible documents directly to the REX Mobile Mammography office at (919)784-4205.



Please Return Application to:

Harnett County Health Department
Attn: Debra Hawkins
307 W. Cornelius Harnett Blvd.
Lillington, NC 27546

To be eligible for screening, you must:

- Must have an active physician or medical home
- Must have no previous history of breast cancer
- Must not have any abnormal symptoms (i.e. pain, new lump or nipple discharge – please contact your physician for follow up if you have any of these symptoms.)
- Must be at least 35 years of age (confirm coverage with insurance carrier)
- Must not have had a mammogram in the last 12 months (confirm coverage with insurance carrier if less than 12 months)
- Make us aware if you have breast implants so you can be scheduled appropriately
- May not be pregnant

Please be sure to include the full name, address and phone number of your physician on registration form. All patients **must** have a physician.
Please fax your photo id and insurance card prior to the appointment or make sure to bring at appointment to prevent delays or rescheduling.
Please also be sure to indicate where you had your last mammogram. If your previous mammogram was with REX, please indicate it on the form.
Prior to your appointment, call the mammography facility and have them send your last mammogram films and report to: REX Mobile Mammography, c/o Breast Care Center, 3100 Duraleigh Road, Suite 204, Raleigh, NC 27612
If you are uncertain about your previous mammography facility, please call your physicians office and have them check your medical record report.

Attention to these guidelines will help us greatly in the registration process and will reduce the wait time on the day of your exam. Thank you for choosing REX Mobile Mammography to provide your annual mammogram.

If you have any questions, contact your site coordinator, or you may call REX Mobile Mammography at (919) 784-4210.

UNC REX HEALTHCARE

Susan G. Komen. NORTH CAROLINA TRIANGLE TO THE COAST

revised:7/8/16

UNC REX Healthcare
Raleigh, NC 27612

patient identification

REX Mobile Mammography Pre-Exam Form

All patients must also be registered through the site coordinator:

Time: _____________ Date of appointment: _____________

Registration Information:

Name (Last, First, Middle):_______________________________________

DOB: _____________ Race:________ Language:_____________

Address: ____

City: ______________ State: ________ Zip: ______________

Home Phone: _______________ Work Phone:___________________

Mother's Maiden Name:_____________________________________

Last Four of Social Security #: _________ Marital Status:______________

Please provide your email address for our records: __________________________

This must be completed to schedule an appointment.

Physician Information:

Name of Physician: ____

Name of Practice: ____

Address (in full): ____

Phone: __________________ Fax: ________________

Insurance Information (attach a copy of your insurance card)

Are you enrolled in an insurance plan? ___yes ___no

If no, please complete REX Mammography Assistance Application.

If yes, please attach insurance card.

Have you ever been to REX or UNC? ___yes ___no

REX MEDICAL RECORD NUMBER:________________________

Breast Health Information:

Reason for today's mammogram: Routine_____ Other____________

Have you had breast cancer? ___yes ___no

Date of your last menstrual period: ______________________________________

Are you breastfeeding? ___yes ___no

Number of pregnancies: _____ Age at first Pregnancy: _______

Are you currently taking hormones? ___________________________

Are you on birth control? ___yes ___no

Have you had any breast surgeries (including augmentation) or biopsies? ______

If so, list, date: ____________ type:_____________ side: _____

result: ____

____

____

Last Mammogram:

Where: __________________________

When:___________________________

Date of last clinical breast exam? ______

Emergency Contact:

Name (first and last): __________________________

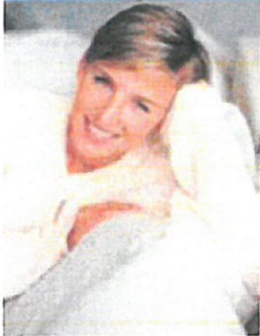
Relationship: ______________________________

Address: _________________________________

Telephone: ____________ home: ______________

revised:6/16

UNC REX Healthcare Mammography Assistance Program Criteria



The REX Mammography Assistance Program is designed to help uninsured women, who do not qualify for Breast Cervical Cancer Control Program (BCCCP) in our surrounding areas and in need of a screening mammogram through the REX Mobile Mammography Coach at their medical clinic, the local health department or a community event. We also provide diagnostic imaging as recommended by a medical provider through the REX Breast Care Center.

Eligibility:

- Women must have a medical home (if you do not, please contact your local health department)
- Women must be age 35 years and older (screening only)
- Women must be age 30 years and older (diagnostic/ultrasound only w/order)
- Women in need of a screening or diagnostic mammogram and breast ultrasound
- Women without medical insurance who meet the financial criteria (see table below)
- Complete application and submit with provider's referral for diagnostic imaging
- Complete Application and submit with Pre exam form for REX Mobile screening.

Size of Family	Maximum Household Income
1	$25,000
2	$28,000
3	$30,000
4	$35,000
5	$40,000
6	$40,000
7	$45,000
8 or more	$45,000

How to Qualify:

- All screenings are scheduled on the REX Mobile Mammography Coach. If the mobile unit visits your medical clinic or local health department, feel free to contact them to register for a free mammogram.
- All diagnostic mammograms and breast ultrasounds are scheduled at REX Breast Care Center with a provider's order. If you have an immediate need or history of breast cancer, please contact your medical provider for a valid order to have the appropriate exam done.
- Applications must be completed on all REX Mammography Assistance applicants and can be done through their provider or faxed to us at 919-784-4205.
- If the REX Mobile Mammography unit does not come to your medical provider's office or local health department, please contact 919-784-2143 to qualify.

Coverage:

This is applicable to screenings, diagnostic mammograms and breast ultrasound services at REX.

PLEASE NOTE THE FOLLOWING:

- **UNC REX reserves the right to use their own discretion on covering any/all cases that may or may not fall exactly within the eligibility criteria.**
- **Household income should include patient requesting our service and her spouse.**
- **The number of people in household must be reflected on this application. This is the number of exemptions claimed on your tax return. Applicants may be subject for review and required to provide proof of income.**

Rex Healthcare's Mammography Assistance Application

Please fax back to 919-784-4205 or mail to Rex Mammography Assistance Program at 3100 Duraleigh Road, Suite 204, Raleigh, NC 27612

Patient Full Name: ______________________________

Patient Phone Number: ______________________________

Date of Birth: ______________________________

Referred By: ____________________ Phone Number: __________

Please circle below the Mammography Service and location you need to be scheduled:

REX Breast Care Center in Raleigh or REX Healthcare of Wakefield

Bilateral Diagnostic Mammogram   Unilateral Diagnostic

Bilateral Ultrasound   Unilateral Ultrasound

REX Mobile Mammograpny Coach   Screening Mammogram

Is this your first mammogram? ☐ yes ☐ no

If not, where was your last mammogram? ____________________ Date of mammogram: __________

Currently, are you having any problems with your breasts? ☐ yes ☐ no

If yes, please describe your current symptoms ______________________________

Do you have a personal history of breast cancer? ☐ yes ☐ no

Do you have implants? ☐ yes ☐ no

All patients must have a physician to be seen. Please provide the name of your physician in full:

Do you have insurance? ☐ yes ☐ no

If yes, please provide insurance carrier name: ______________________________

Number of dependents in household (number of exemptions claimed on tax return): __________

Annual income (include patient and spouse): ______________________________

This application is completed by: ____________________ Phone number: __________

If any information provided proves to be untrue, I understand the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Patient signature (to be signed at time of appointment): ______________________________

Approved by (REX Staff): ______________________________

Not Approved by (REX Staff): ______________________________

revised 7/16

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