AULTCARE

AULTRA
ADMINISTRATIVE GROUP

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Breast Cancer Preventive Medications Enrollment Form

PATIENT INFORMATION			
Patient Name	☐ Female	Allergies ☐ NKDA	
Date of Birth	SSN#	Weight _____ ☐ lb ☐ kg Date	
Address	City	State	
Phone # (Home)	(Work)	Email address (optional)	

INSURANCE INFORMATION	
Primary Insurance	Policyholder
Group #	Policy #

MEDICAL INFORMATION (PLEASE ANSWER ALL QUESTIONS)

Diagnosis:_____ ICD-10 code:_____

1. Is the patient female and age 35 or older? ☐ yes ☐ no

2. Does the patient have personal history of invasive breast cancer? ☐ yes ☐ no

3. Is the patient at increased risk than for invasive breast cancer (but has never been diagnosed) and meet one of the following high risk criteria (please check which applies): ☐ yes ☐ no
   - ☐ Has a known mutation, or error, in a gene linked to the disease, such as *BRCA1* or *BRCA2*.
   - ☐ Has a strong family history of breast or ovarian cancer.
   - ☐ Has personal history of Ductal or Lobular Carcinoma in situ.
   - ☐ Is of certain ethnic backgrounds, such as Ashkenazi (Eastern or Central European) Jewish decent.
   - ☐ Other:_____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity
☐ Raloxifene	☐ 60mg	_____	#_____
☐ Tamoxifen	☐ 10mg tablets ☐ 20mg tablets	_____	#_____

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION	
Physician Name	Office Contact
Phone	Fax
Address	City/State/Zip

Physician's Signature _____ **Date** _____