

Visit Date ____/____/____ (MM / DD/ YYYY)	Referral Date ____/____/____
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Name _____
 (Last) (First) (M.I.)

ID NUMBER	Date of Birth ____/____/____
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Race (check all that apply) White Black/African American Asian Native Hawaiian or Other Pacific Islander
 American Indian or Alaska Native Unknown/Prefer not to Answer

Ethnicity Are you Hispanic or Latino? Yes No Prefer Not to Answer

Patient Navigation: Required if PN delivered consistent with CDC policy (refer to BCCCP Training Manual)

Patient Navigation Needs Assessment Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Navigation Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Navigation Paid by Federal Funds: <input type="checkbox"/> Yes <input type="checkbox"/> No (or if PN not delivered) <input type="checkbox"/> Unknown
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Date of Last PAP ____/____/____ MM YYYY If 'Unknown' use 88/8888 If 'Never' or more than 10 years since last PAP use 00/0000	High Risk for Cervical Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed/Unknown
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Pelvic Exam

Date of Pelvic Exam ____/____/____	Date of Pelvic Results ____/____/____	Pelvic Paid By: <input type="checkbox"/> Federal Funds <input type="checkbox"/> State Funds <input type="checkbox"/> Non-BCCCP
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Pelvic Exam Results
 Normal Abnormal; follow up required Pelvic exam not indicated Pelvic exam refused

Pap Screening

Purpose for Pap Test
 Routine Screening Patient under Surveillance for previous abnormal test Referred in for diagnostics
 Pap After Primary HPV+ No Pap, Diagnostic Only **(Referral Date Required)**

Date of Pap ____/____/____	Pap Paid By: <input type="checkbox"/> Federal Funds <input type="checkbox"/> State Funds <input type="checkbox"/> Non-BCCCP
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Pap Results:

<input type="checkbox"/> Negative for intraepithelial lesion or malignancy	<input type="checkbox"/> * Adenocarcinoma in situ (AIS)
<input type="checkbox"/> Atypical squamous cells of undetermined significance (ASC-US)	<input type="checkbox"/> Adenocarcinoma
<input type="checkbox"/> Low Grade SIL (including HPV changes)	<input type="checkbox"/> Other (Malignant neoplasm)
<input type="checkbox"/> * Atypical squamous cells cannot exclude HSIL (ASC-H)	<input type="checkbox"/> Results Pending
<input type="checkbox"/> * High Grade SIL	<input type="checkbox"/> Results Unknown
<input type="checkbox"/> * Atypical Glandular Cells	<input type="checkbox"/> Infection/Inflammation
<input type="checkbox"/> * Squamous Cell Carcinoma	

***All screening results with an asterisk (*) require diagnostic work-up.**

HPV Screening

Date of HPV ____/____/____	HPV Paid by: <input type="checkbox"/> Federal Funds <input type="checkbox"/> State Funds <input type="checkbox"/> Non-BCCCP	Indication for HPV Test <input type="checkbox"/> Co-Test/Screening <input type="checkbox"/> Reflex <input type="checkbox"/> Test not done <input type="checkbox"/> Unknown
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HPV Test Result:

<input type="checkbox"/> *Positive w/ positive genotyping (types 16 or18)	<input type="checkbox"/> Positive w/ negative genotyping (positive HPV, but no types 16 or 18; NEED TO DIRECT TO PAP CYTOLOGY;)
<input type="checkbox"/> Positive w/ genotyping not done	<input type="checkbox"/> Negative

***All screening results with an asterisk (*) require diagnostic work-up.**

Follow-up Plan

For any Abnormal Pap or HPV + with positive genotyping, is **Diagnostic Work-up Planned?** Yes No

Diagnostic Work Up Procedures

Date of Colposcopy

____/____/____
(MM DD YYYY)

Colposcopy Paid By:

Federal Funds State Funds Non-BCCCP

Colposcopy Results:

Colpo without Biopsy Colpo with Biopsy/and or ECC

Date of Cervical Biopsy ____/____/____

Biopsy Paid By:

Federal Funds State Funds Non-BCCCP

Biopsy Results:

Normal
 HPV/Condylomata/Aytpia
 CIN I/mild dysplasia

CIN II /moderate dysplasia
 * CIN III/ Carcinoma in-situ/ severe dysplasia
 * Invasive cervical carcinoma
 * Invasive adenocarcinoma

Other non-cervical cancer
 Low grade SIL
 High Grade SIL

***All results with an asterisk (*) require Treatment.**

ECC, LEEP, CKC requires prior approval from Regional Nurse Consultant

Date of ECC

____/____/____

ECC Paid By:

Federal Funds State Funds Non-BCCCP

Final Diagnosis Result of ECC

Normal
 HPV/Condylomata/Aytpia
 CIN I/mild dysplasia

CIN II /moderate dysplasia
 * CIN III/ Carcinoma in-situ/ severe dysplasia
 * Invasive cervical carcinoma
 * Invasive adenocarcinoma

Other non-cervical cancer
 Low grade SIL
 High Grade SIL

Date of LEEP

____/____/____

LEEP Paid By:

Federal Funds State Funds Non-BCCCP

Final Diagnosis Result of LEEP:

Normal
 HPV/Condylomata/Aytpia
 CIN I/mild dysplasia

CIN II /moderate dysplasia
 * CIN III/ Carcinoma in-situ/ severe dysplasia
 * Invasive cervical carcinoma
 * Invasive adenocarcinoma

Other non-cervical cancer
 Low grade SIL
 High Grade SIL

Date of CKC

____/____/____

CKC Paid By:

Federal Funds State Funds Non-BCCCP

Final Diagnosis Result of CKC:

Normal
 HPV/Condylomata/Aytpia
 CIN I/mild dysplasia

CIN II /moderate dysplasia
 * CIN III/ Carcinoma in-situ/ severe dysplasia
 * Invasive cervical carcinoma
 * Invasive adenocarcinoma

Other non-cervical cancer
 Low grade SIL
 High Grade SIL

Cervical Diagnostic Disposition

Diagnostic Dx Date ____/____/____

Diagnostic Disposition:

No cervical cancer; case closed
 Results pending
 Patient died

Moved out of county/state
 Unable to obtain results
 Refused to follow-up

Cervical cancer diagnosed
 Lost to follow-up

Diagnostic Stage:

Stage 0 (cervical cancer in-situ)
 Stage I

Stage II
 Stage III
 Stage IV
 Stage Unknown

Summary Regional
 Summary Distant
 Summary Local

Cervical Treatment Disposition

Treatment Date

____/____/____

Treatment Disposition:

Treatment not needed
 Unable to obtain results
 Treatment initiated

Treatment pending
 Patient died

Patient moved
 Refused treatment