



Cancer Detection Programs: Every Woman Counts

Recipient ID# 9 A Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy

Recipient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Provider ID# \_\_\_\_\_

I Pap Test

1. PREVIOUS Pap Test?  No  Unknown - Woman doesn't know **1b. Date of PREVIOUS Pap Test**  
 Yes - Date known  Unknown - Woman wasn't asked / not recorded  
 Yes - Date unknown but within last 5 years  Unknown - Woman refused to answer  
 Yes - Date unknown but more than 5 years

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

2. Reason for CURRENT Pap Test  Routine Pap test  Pap test for management of previous abnormal result  Pap test not done - Diagnostic work-up and/or HPV test only  Pap test not paid by CDP - Client referred for diagnostics only (Report Pap Test result in Item 7)

Complete Item 3

3. Cervical Diagnostic Referral Date \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy

4. Date of CURRENT Pelvic Exam \_\_\_\_/\_\_\_\_/\_\_\_\_ mm dd yyyy

5. Specimen Adequacy  Satisfactory  Unsatisfactory

6. Specimen Type  Conventional Smear  Liquid Based  Other  Unknown

7. CURRENT Pap Test Result  Negative for intraepithelial lesion or malignancy  Atypical squamous cells of undetermined significance (ASC-US)  Low grade SIL (LSIL) - including HPV changes  Atypical squamous cells cannot exclude HSIL (ASC-H)  High grade SIL (HSIL)

Squamous Cell Carcinoma  Abnormal Glandular Cells (AGC)  AGC - Neoplastic  Adenocarcinoma In Situ (AIS)  Adenocarcinoma  Other - Please specify \_\_\_\_\_

Immediate work-up needed (Item 9)  Short term follow-up recommended (Item 9)

**7b. Date of CURRENT Pap Test**  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

8. CURRENT HPV Test Result  Test Not Done  Positive  Negative

**8b. Date of CURRENT HPV Test**  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

II Additional Procedures Needed to Complete Cervical Cycle?

9.  Not needed or planned - Routine rescreen (Resume annual screenings)  
 Not needed or planned - Short term follow-up (Next appointment planned in less than 12 months)  
 Needed or planned - Immediate work-up (Immediate diagnostic work-up is planned)

III Cervical Diagnostic Procedures • All dates below must be ON or AFTER the Date of CURRENT Pap Test •

10. Type of Procedure (Not Covered by CDP:EWC)  Colposcopy without Biopsy  Colposcopy with Biopsy and/or ECC  Loop Electrosurgical Excision Procedure (LEEP)  Cold Knife Cone (CKC)  Endocervical Curettage alone (ECC)

**10b. Date of Procedure**

____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____
mm dd yyyy	mm dd yyyy	mm dd yyyy

11. Other Cervical Procedure Performed (Not Covered by CDP:EWC)  Excision of endocervical polyps  Endometrial biopsy (EMB)  Biopsy of other structure (e.g., vagina, vulva)  Other gynecologic consults  Other - Please specify \_\_\_\_\_

**11b. Date of Procedure**  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

IV Cervical Work-up Status and Final Diagnosis Information

12. Work-up Status  Work-up complete  Lost to follow-up (Two phone calls and certified letter sent)  Work-up refused (Patient refused, obtained insurance, moved, or changed PCP)  Died before work-up complete

**12b. Date of Work-up Status**  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

13. Final Diagnosis  Normal / Benign reaction / inflammation  HPV / Condylomata / Atypia  CIN I / mild dysplasia (biopsy diagnosis)  CIN II / moderate dysplasia (biopsy diagnosis)  CIN III / severe dysplasia / CIS or AIS of cervix (biopsy diagnosis)  Invasive Cervical Carcinoma - Squamous Cell or Adenocarcinoma (biopsy diagnosis)  Low grade SIL (biopsy diagnosis)  High grade SIL (biopsy diagnosis)  Other - Please specify \_\_\_\_\_

Treatment Status required if final diagnosis is CIN II, CIN III / CIS / AIS, HSIL or Invasive Cervical Carcinoma (Item 14)

**13b. Date of Final Diagnosis**  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

V Cervical Cancer Treatment Information

14. Treatment Status  Treatment started  Lost to follow-up (Two phone calls and certified letter sent)  Treatment refused  Treatment not needed  Died before treatment started

**14b. Date of Treatment Status**  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

15. Patient enrolled in BCCTP. Check this box ONLY if you have completed the BCCTP enrollment process.

Clinician's Signature \_\_\_\_\_ Date \_\_\_\_\_