

**Client Identification**

Program # \_\_\_\_\_ Last Name \_\_\_\_\_  
 ID # \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 First Name \_\_\_\_\_



Screening Visit Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) Facility # \_\_\_\_\_  
 (Enter Visit Date from Screening Form)

**Cervical Diagnostic Procedure**

1. Colposcopy without Biopsy <input type="radio"/> 1. Yes <input type="radio"/> 2. No	4. Cold Knife Cone (CKC) (preauthorize @ 515.242.6200) <input type="radio"/> 1. Yes <input type="radio"/> 2. No
2. Colposcopy with Biopsy and/or ECC <input type="radio"/> 1. Yes <input type="radio"/> 2. No	5. Endocervical Curettage <i>alone</i> (ECC) <input type="radio"/> 1. Yes <input type="radio"/> 2. No
3. Loop Electrosurgical Excision Procedure (LEEP) (preauthorize @ 515.242.6200) <input type="radio"/> 1. Yes <input type="radio"/> 2. No	6. Other <input type="radio"/> 1. Yes → Specify Procedure: _____ <input type="radio"/> 2. No

**Cervical Diagnostic Procedure Payer**

7. Was at least one of the above procedures paid for by BCCEDP?  
 1. Yes  
 2. No  
 3. Unknown

**Cervical Diagnostic Results**

8. Status of final diagnosis  
 1. Work-up complete  
 2. Lost to follow-up → 8a. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ STOP HERE (mm / dd / yyyy)  
 3. Work-up refused →

8b. Date of Final Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy)

8c. Final diagnosis  
 1. Normal/benign reaction/inflammation  
 2. HPV/Condylomata/Atypia

3. CIN 1 - Mild dysplasia  
 4. CIN 2 - Moderate dysplasia  
 5. CIN 3 - Severe dysplasia/Carcinoma in situ/Stage 0  
 6. Invasive cervical cancer  
 7. Low grade SIL  
 8. High grade SIL  
 9. Other (specify): \_\_\_\_\_

8d. Status of Treatment  
 1. Started → 8e. Date started: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) → 8f. Treatment paid by:  
 1. Medicaid  
 2. Medicare  
 3. Private Insurance  
 4. Self  
 5. Other  
 6. Unknown  
 2. Pending  
 3. Lost to follow-up } 8g. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy)  
 4. Refused  
 5. Not indicated

8h. Short-term visit recommended? (less than 9 months)  1. Yes →  2. No

8i. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / yyyy)

8j. Referred to American Cancer Society (ACS) for additional services  
 1. Yes  
 2. No  
 3. Client Refused