Client Identification	Client History	Screening Measurements
Program # __ __ __ ID # __ __ __ __ __ __ __ __ __ Visit Date: __ __ / __ __ / __ __ __ __ ***(Earliest of 10a, 11a, 12a, 13a, 14a below)*** *(mm / dd / yyyy)* ☐ *Limited* ☐ *Comprehensive* Last Name _____ First Name _____ Middle Initial _____ Facility # ___ ___ ___ ___ ___ ANSI # ___ ___ ___ ___ ___ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	1. High Risk for Breast Cancer? ◯ 1. Yes ◯ 2. No ◯ 3. Not assessed/Unknown 2. High Risk for Cervical Cancer? ◯ 1. Yes ◯ 2. No ◯ 3. Not assessed/Unknown 3. Has the woman ever had a pap test? ◯ 1. Yes → 3a. Date previous: __ __ / __ __ __ __ ***(month/year: Enter 06 if month unknown)*** ◯ 2. No ◯ 3. Unknown	4. Height __ __ inches 5. Weight __ __ __ pounds 6. Waist Circumference __ __ inches 7. Hip Circumference __ __ inches ◯ Unable to obtain 8. Blood Pressure ***(two readings required):*** 8a. 1st Reading: __ __ __ / __ __ __ mmHg 8b. 2nd Reading: __ __ __ / __ __ __ mmHg ***Avg. value > 180/or/110 needs immediate workup** ◯ Unable to obtain 9. Measurement Date: __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*

Examination	Date Performed/Type	Result	Payer
10. **Clinical Breast Exam** ◯ 1. Performed → ◯ 2. Not performed ◯ 3. Refused	10a. *CBE Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*	10b. *CBE Result* ◯ 1. Normal or benign (including fibrocystic, lumpiness, or nodularity) ◯ ***2. Abnormality—suspicious for cancer**	10c. *CBE paid by* ◯ 1. BCCEDP ◯ 2. Other ◯ 3. Unknown ◯ 4. BCCEDP / Insurance ◯ 5. Insurance Only
11. **Mammogram** ◯ 1. Performed; routine screening mammogram → ◯ 2. Performed to evaluate symptoms, positive CBE, or previous abnormal mammogram → ◯ 3. Performed, not paid by BCC; patient referred for DX Evaluation: → *DX referral date:* __ __ / __ __ / __ __ __ __ ◯ 4. Not performed ◯ 5. Refused	11a. *Mamm. Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*	11b. *Mammogram Result* ◯ 1. Negative (BI-RADS 1) ◯ 2. Benign (BI-RADS 2) ◯ 3. Probably benign—short interval follow-up indicated (BI-RADS 3) ◯ ***4. Suspicious abnormality— consider biopsy (BI-RADS 4)** ◯ ***5. Highly suggestive of malignancy (BI-RADS 5)** ◯ ***6. Need evaluation or Film comparison (BI-RADS 0)**	11c. *Mamm paid by* ◯ 1. BCCEDP ◯ 2. Komen ◯ 3. Other ◯ 4. Unknown ◯ 5. BCCEDP / Insurance ◯ 6. Insurance Only
12. **Screening MRI** ◯ 1. Performed → ◯ 2. Not performed ◯ 3. Refused	12a. *MRI Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*	12b. *MRI Result* ◯ 1. Negative (Category1) ◯ 2. Benign (Category 2) ◯ 3. Probably benign (Category 3) ◯ 4. Suspicious (Category 4) ◯ 5. Highly suggestive of malignancy (Category 5) ◯ 6. Known malignancy (Category 6) ◯ 7. Incomplete—Need additional imaging evaluation (Category 0)	12c. *MRI paid by* ◯ 1. BCCEDP ◯ 2. Other ◯ 3. Unknown ◯ 4. BCCEDP / Insurance ◯ 5. Insurance Only
13. **Pap Test** ◯ 1. Performed; routine pap test → ◯ 2. Performed; patient under surveillance for previous abnormal test → ◯ 3. Performed, not paid by BCC; patient referred for DX Evaluation: → *DX referral date:* __ __ / __ __ / __ __ __ __ ◯ 4. Performed Pap after primary HPV+ → ◯ 5. Not performed ◯ 6. Refused	13a. *Pap Test Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*	13b. *Pap Test Result* ◯ 1. Negative ◯ 2. ASC-US ◯ 3. Low grade SIL (including HPV changes) ◯ ***4. ASC-H** ◯ ***5. High grade SIL** ◯ ***6. Squamous cell carcinoma** ◯ ***7. Atypical glandular cells** ◯ ***8. Adenocarcinoma in situ*** ◯ ***9. Adenocarcinoma** ◯ 10. Other_____ ◯ 11. Unsatisfactory	13c. *Pap paid by* ◯ 1. BCCEDP ◯ 2. Other ◯ 3. Unknown ◯ 4. BCCEDP / Insurance ◯ 5. Insurance Only
14. **HPV Test** ◯ 1. Co-Test or Screening → ◯ 2. Reflex → ◯ 3. Not performed ◯ 4. Refused	14a. *HPV Test Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*	14b. *HPV Test Result* ◯ 1. Positive with genotyping not done/unknown ◯ 2. Negative ◯ *3. **Positive with positive genotyping (types 16 or 18)** ◯ 4. Positive with negative genotyping (positive HPV, but not types 16 or 18) ◯ 5. Unknown	14c. *HPV paid by* ◯ 1. BCCEDP ◯ 2. Other ◯ 3. Unknown ◯ 4. BCCEDP / Insurance ◯ 5. Insurance Only

CARE FOR YOURSELF
Breast & Cervical Cancer Screening

*** Immediate Diagnostic Testing Indicated**

Client Identification

Program # __ __ __ Last name _____ Visit Date __ __ / __ __ / __ __ __ __ (mm / dd / yyyy)

ID # __ __ __ __ __ __ __ __ __ First Name_____ Middle Initial _____

Follow-up Plan

15. Breast diagnostic workup planned? ⬭ 1. Yes ⬭ 2. No
16. Breast short-term (less than 9 months) visit recommended? ⬭ 1. Yes ⬭ 2. No
    → 16a. Breast short-term visit date: __ __ / __ __ __ __ *(mm/yyyy)*
17. Cervical diagnostic workup planned? ⬭ 1. Yes ⬭ 2. No
18. Cervical short-term (less than 9 months) visit recommended? ⬭ 1. Yes ⬭ 2. No
    → 18a. Cervical short-term visit date: __ __ / __ __ __ __ *(mm/yyyy)*
19. **Alert** Blood Pressure workup planned? ⬭ 1. Yes ⬭ 2. No ⬭ 3. Follow-up—workup by alternate provider ⬭ 4. Refused
20. **Abnormal** Blood Pressure follow-up recommended? ⬭ 1. Yes ⬭ 2. No
    → 20a. Abnormal follow-up date: __ __ / __ __ __ __ *(mm/yyyy)*

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