West Virginia Breast & Cervical Cancer Screening Program
You're Worth It

West Virginia Department of Health and Human Resources
Office of Maternal, child & Family Health

West Virginia Breast and Cervical Cancer Screening Program
Cervical Diagnostic Report

Referral Facility: _____ **Phone: (_____)**_____
Pap Test Date (mm/dd/yyyy): _____/_____/_____ **Pap Test Result:** _____
Client Name (Last, First, MI): _____
Social Security #: _____ _____ _____ **Date Of Birth:** _____/_____/_____

Cervical Procedure(s) Performed

Procedures Paid by WVBCCSP

Date Performed (mm/dd/yyyy): _____/_____/_____

Procedure A

- ☐ *Colposcopy with Biopsy*
- ☐ *Colposcopy with ECC*
- ☐ *Colposcopy without Biopsy*
- ☐ *Endocervical Curettage*
- ☐ *Endometrial Biopsy with Colposcopy*: Only reimbursed with a Pap test result of AGC or Adenocarcinoma.

Procedures Paid by D&T Fund or MTA

Date Performed (mm/dd/yyyy): ____/_____/_____

Procedure B

- ☐ *Cervical Polyp Removal*
- ☐ *Cold Knife Conization*
- ☐ *Cryotherapy*
- ☐ *Endocervical Curettage*
- ☐ *Hysterectomy*
- ☐ *Laser*

These procedures require prior approval to be reimbursed.

Cervical Procedures A Result:

- ☐ *Adenocarcinoma*
- ☐ *CIN I*
- ☐ *CIN II*
- ☐ *CIN III/CI*
- ☐ *Invasive (WNL)*
- ☐ *No Tissue Present*
- ☐ *Not Done, Other Unknown Reason*
- ☐ *Other, Non-Malignant Abnormality (HPV, Condylomata)*
- ☐ *Refused*
- ☐ *Unknown*

Date of Findings (mm/dd/yyyy): _____/_____/_____

Cervical Procedure B Result:

- ☐ *Adenocarcinoma*
- ☐ *CIN I*
- ☐ *CIN II*
- ☐ *CIN III/ CIS*
- ☐ *Invasive (WNL)*
- ☐ *No Tissue Present*
- ☐ *Not Done, Other Unknown Reason*
- ☐ *Other, Non-Malignant Abnormality (HPV, Condylomata)*
- ☐ *Refused*
- ☐ *Unknown*

Date of Findings (mm/dd/yyyy): _____/_____/_____

Cervical Recommendation A

Date Patient Notified (mm/dd/yyyy): _____/_____/_____

- ☐ *Colposcopy with Biopsy*
- ☐ *Colposcopy without Biopsy*
- ☐ *Cold Knife Conization*
- ☐ *Definitive treatment*
- ☐ *Follow routine Screening*
- ☐ *Hysterectomy*
- ☐ *LEEP*
- ☐ *Other:* _____
- ☐ *Short Term follow-Up in Six (6) Months*

Cervical Recommendation B

Date Patient Notified (mm/dd/yyyy): _____/_____/_____

- ☐ *Hysterectomy*
- ☐ *Short Term follow-Up in Six (6) Months*

Status of Final Diagnosis

Date (mm/dd/yyyy): _____/_____/_____

- ☐ *Complete*
- ☐ *Deceased*
- ☐ *Lost to Follow-Up*
- ☐ *Refused*

Final Diagnosis

Date (mm/dd/yyyy): _____/_____/_____

- ☐ *CIN I/Mid Dysplasia*
- ☐ *CIN II/Moderate Dysplasia**
- ☐ *CIN III/Sever Dysplasia/CIS (Stage0)**
- ☐ *HSIL**
- ☐ *HPV/Condylomata/Atypia*
- ☐ *Invasive Cervical Cancer**
- ☐ *LSIL*
- ☐ *Normal/Benign Reaction /Inflammation*
- ☐ *Other:* _____

* Treatment status and treatment date required for these diagnoses

Treatment Status

Date (mm/dd/yyyy): _____/_____/_____

- ☐ *Client Refused*
- ☐ *Not Indicated/Not Needed*
- ☐ *Financial Problems*
- ☐ *Treatment Started*
- ☐ *Lost to Follow-Up*
- ☐ *Refused by Client*
- ☐ *Other Problems*: _____