



West Virginia Breast and Cervical Cancer Screening Program Patient Data Form

WVBCCSP Screening Facility: _____		Visit Date: ____/____/____	
WVBCCSP #: _____			
Patient Name (Last, First, MI): _____			
Social Security #: _____		Date of Birth: ____/____/____	
VISIT TYPE <input type="checkbox"/> Initial <input type="checkbox"/> Annual Cervical <input type="checkbox"/> Ref. for Prev. Enroll <input type="checkbox"/> Annual Routine <input type="checkbox"/> Repeat Pap/CBE <input type="checkbox"/> Ref. for MTA <input type="checkbox"/> Annual Breast <input type="checkbox"/> Ref. for Enrollment		CLINICIAN TIME Clinician Time: _____ Minutes (*ONLY report time spent with patient)	
CERVICAL SERVICES DATA Prior Pap test? <input type="checkbox"/> Yes, Date: ____/____/____ <input type="checkbox"/> No (estimated or partial dates accepted) Does patient have a cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No Was hysterectomy due to cervical cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No		SMOKING STATUS/TOBACCO REFERRALS Smoking History? <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked Referred to a tobacco QuitLine: <input type="checkbox"/> Yes <input type="checkbox"/> No Referred to other tobacco cessation service: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HIGH RISK FOR CERVICAL CANCER? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Assessed <input type="checkbox"/> Unknown		BREAST SERVICES DATA Prior Mammogram? <input type="checkbox"/> Yes, Date: ____/____/____ <input type="checkbox"/> No Previous History of Breast Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Age 40-49? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PELVIC EXAM PERFORMED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date Performed: ____/____/____		HIGH RISK FOR BREAST CANCER? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Assessed <input type="checkbox"/> Unknown	
PAP TEST Date Performed: ____/____/____ Check ONLY one (1) result: <input type="checkbox"/> Adenocarcinoma* <input type="checkbox"/> Adenocarcinoma In Situ (AIS)* <input type="checkbox"/> Atypical glandular cells (AGC)* <input type="checkbox"/> Atypical squamous cells, cannot exclude HSIL (ASC-H)* <input type="checkbox"/> Atypical squamous cells of undetermined significance (ASC-US) <input type="checkbox"/> High-grade SIL (HSIL)* <input type="checkbox"/> Low-grade SIL (LSIL)/including HPV changes <input type="checkbox"/> Negative for intraepithelial lesion or malignancy <input type="checkbox"/> Other-specify: _____ <input type="checkbox"/> Result Pending <input type="checkbox"/> Result unknown, presumed abnormal, non-program* <input type="checkbox"/> Squamous cell carcinoma* <input type="checkbox"/> Unsatisfactory Indication for Pap test: <input type="checkbox"/> Screening (routine Pap test) <input type="checkbox"/> Surveillance for positive, abnormal test <input type="checkbox"/> Non-program Pap, referred in for dx evaluation <input type="checkbox"/> Pap after primary HPV+ <input type="checkbox"/> No Pap <input type="checkbox"/> No cervical services, Breast record only <input type="checkbox"/> Unknown		CLINICAL BREAST EXAM Date Performed: ____/____/____ Check ONLY one (1) result: <input type="checkbox"/> Normal/Benign findings-schedule CBE in one year <input type="checkbox"/> Abnormality suspicious for cancer-dx evaluation needed* Select all that applies <input type="checkbox"/> Bloody/serous nipple discharge <input type="checkbox"/> Discrete palp mass (suspicious for cancer) <input type="checkbox"/> Focal pain or tenderness <input type="checkbox"/> Skin dimpling/retraction <input type="checkbox"/> Nipple/areolar scaliness <input type="checkbox"/> Discrete palp mass (diagnostic Benign) <input type="checkbox"/> Not done normal CBE for past 12 months <input type="checkbox"/> Not done other/unknown reason <input type="checkbox"/> Refused	
		BREAST SERVICES PAYMENT Breast Services Paid for by WVBCCSP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		GENERAL COMMENTS—Breast and cervical Services Diagnostic workup Planned? Breast <input type="checkbox"/> Yes <input type="checkbox"/> No Cervical <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Comments: _____ _____ _____ _____	
HPV Date Performed: ____/____/____ Check ONLY one (1) result: <input type="checkbox"/> Positive (genotyping done, types 16 or 18) <input type="checkbox"/> Positive (genotyping done, NOT types 16 or 18) <input type="checkbox"/> Positive (genotyping NOT done) <input type="checkbox"/> Negative Indication for HPV test: <input type="checkbox"/> Co-test/ or Screening <input type="checkbox"/> Reflex <input type="checkbox"/> Test not done <input type="checkbox"/> Unknown		REQUIRED SIGNATURES Exam performed by: _____ _____ Clinician's Signature Date: ____/____/____	
CERVICAL SERVICES PAYMENT Cervical Services Paid for by WVBCCSP? <input type="checkbox"/> Yes <input type="checkbox"/> No			

* Indicates Diagnostic Work-up Required