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

WV Breast and Cervical Cancer Screening Program
Patient Navigation Form

WVBCCSP Screening Facility: ______________________________

WVBCCSP #: ____________________ **Initial Contact Date** (mm/dd/yyyy): ________ /________ / ________

Social Security #: _______ -________ -________ **Date of Birth** (mm/dd/yyyy): ________ /________ / ________

Client Name (Last, First, MI): ______________________________

Reason for Navigation (check only one for which Patient Navigation was initiated)

- ☐ Breast and Cervical Cancer Screening
- ☐ Breast Cancer Screening Only
- ☐ Cervical Cancer Screening Only
- ☐ Breast Diagnostic Services
- ☐ Cervical Diagnostic Services
- ☐ WISEWOMAN Services (for WISEWOMAN providers only)
- ☐ Breast Cancer Treatment
- ☐ Cervical Cancer Treatment

Medical Insurance

- ☐ Insured: Medicaid
- ☐ Insured: Medicare
- ☐ Insured: Private
- ☐ Uninsured: WVBCCSP
- ☐ Uninsured: Self Pay

Barriers	Resolved?	
☐ Language: Interpreter needed	☐ Yes	☐ No
☐ Cultural beliefs/Myths about cancer	☐ Yes	☐ No
☐ Financial issues	☐ Yes	☐ No
☐ Lack of transportation	☐ Yes	☐ No
☐ Caring for child or elder (Needing flexible time appointment)	☐ Yes	☐ No
☐ Fear of test/cancer/CVD	☐ Yes	☐ No
☐ Gender of provider (Prefer same gender care provider)	☐ Yes	☐ No
☐ Work (difficulty requesting time off to receive medical care)	☐ Yes	☐ No
☐ Disability (Needing accommodation for appointment)	☐ Yes	☐ No
☐ Insurance Issues (only when it is a barrier for completing diagnostic services and or treatment)	☐ Yes	☐ No
☐ Knowledge Deficit	☐ Yes	☐ No
☐ Family problems, explain: ____________	☐ Yes	☐ No
☐ Other: ____________________	☐ Yes	☐ No

Resources/Referrals Provided

- ☐ Transportation Assistance/Referral
- ☐ Translator/Language Services
- ☐ Provided Education
- ☐ Financial Assistance Referral
- ☐ Social Work Referral
- ☐ Community Resources Referral
- ☐ Flexible Appointment Time
- ☐ Child/Elder Care Resource Referral
- ☐ Pregnancy Resource Referral
- ☐ Referral to Female Healthcare Provider
- ☐ Referral to County WVDHHR Office
- ☐ Other: ____________________

Documentation of Contacts

Date of Contact	Type of Contact	Result of Each Contact	Contact Notes
	☐ Face-to-Face ☐ Phone ☐ Mail	☐ Spoke with Client ☐ Did Not Speak with Client	
	☐ Face-to-Face ☐ Phone ☐ Mail	☐ Spoke with Client ☐ Did Not Speak with Client	

Patient Navigation Outcomes

- ☐ Completed service needed this time
- ☐ Refused diagnostic testing
- ☐ Refused treatment
- ☐ Lost to Follow-up

Make several attempts before checking these boxes.

*Please feel free to provide additional outcome comments in the notes section.

Notes: ______________________________

Navigator Signature: ____________________ **Date** (mm/dd/yyyy): ______ /______/ ________