**DETEC - CERVICAL CANCER SCREENING CYCLE DATA**

Recipient Name _____ Date of Birth _____ EWC ID# _____

Risk

**1. High Risk for Cervical Cancer** ○ Yes ○ No ○ Not assessed/Unknown

Pap and HPV Tests

**2a. Previous Pap Test?**

○ Yes, date known ○ Yes, date unknown, but within last 10 years

○ No ○ Yes, date unknown, but more than 10 years

**2b. Date of Previous Pap Test**

____/_____ mm/yyyy

○ Unknown

**3. Reason for CURRENT Pap Test**

○ Screening - Routine pap test ○ Pap test after positive primary HPV test (reflex pap test)

○ Pap test for management of previous abnormal result

○ ± Pap test not done - diagnostic work-up and/or HPV test only

○ ± Pap test not paid by EWC - Client referred for diagnostics only

± Complete diagnostic referral date

**4. ± Cervical Diagnostic Referral Date** ____/____/____ mm/dd/yyyy

**5. CURRENT Pap Test Result** (*Immediate work-up needed in #9)

○ Negative for intraepithelial lesion or malignancy

○ Infection/Inflammation/Reactive Changes (do not select)

○ Atypical Squamous Cells of Undetermined Significance (AS

○ Low grade SIL (LSIL) - including HPV changes

○ *Atypical Squamous Cells cannot exclude HSIL (ASC-H)

○ *High grade Squamous Intraepithelial Lesion (HSIL)

○ *Squamous Cell Carcinoma

○ *Atypical Glandular Cells (AGC)

○ *Adenocarcinoma in situ (AIS)

○ *Adenocarcinoma

○ Other - please specify _____

○ Unsatisfactory

**6. Date of CURRENT Pap Test** ____/____/____ mm/dd/yyyy

**7a. Reason for CURRENT HPV Test**

○ Co-test with Pap Test/Screening/Primary HPV test ○ Test not done

○ Reflex HPV Test

**7b. Collection Method**

○ Clinician-Collected Cervical Specimen

○ Self-Collected Vaginal Specimen

**8a. CURRENT HPV Test Result**

○ Negative ○ Positive, positive HPV 16/18 genotyping

○ Positive, genotyping not done or u ○ Positive, negative HPV 16/18 genotyping

**8b. Date of CURRENT HPV Test** ____/____/____ mm/dd/yyyy

Additional Procedures Needed to Complete the Cervical Cycle

**9. Additional Procedures Needed to Complete the Cervical Cycle**

○ Not needed or planned - Routine rescreen

○ Not needed or planned - Short term follow-up

○ Needed or planned - Immediate work-up

Cervical Diagnostic Procedures

| **10a. Type of procedure** | **10b. Date of Procedure: mm/dd/yyyy** | | |
|---|---|---|---|
| ○ Colposcopy without Biopsy | ____/____/____ | ____/____/____ | ____/____/____ |
| ○ Colposcopy with Biopsy and/or ECC | ____/____/____ | ____/____/____ | ____/____/____ |
| ○ † Loop Electrosurgical Excision Procedure (LEEP) | ____/____/____ | ____/____/____ | ____/____/____ |
| ○ † Cold Knife Cone (CKC) | ____/____/____ | ____/____/____ | ____/____/____ |

○ ‡ Endocervical Curretage alone (ECC) ____/____/____ ____/____/____ ____/____/____

**11a. Other Cervical Procedure Performed**

○ ‡ Excision of endocervical polyps ○ † Biopsy of other structure (e.g. vagina, vulva)

○ ‡ Endometrial Biopsy (EMB) ○ Other gynecologic consults ○ Other - please specify _____

**11b. Date of Other Procedure** ____/____/_____ mm/dd/yyyy

† Not covered by EWC ‡ Covered with restrictions

## Cervical Work-up Status and Final Diagnosis Information

| **12a. Work-up Status** | **12b. Date of Work-up Status:** |
|---|---|
| ○ Work-up Complete | ____/____/_____ mm/dd/yyyy |
| ○ Lost to Follow-up | |
| ○ Died before work-up complete | |
| ○ Work-up Refused: Select a reason for refused care: | |

○ Declined care ○ Obtained insurance/Medi-Cal ○ Moved ○ Changed PCP

**13a. Final Diagnosis**

**13b. Date of Final Diagnosis:**

____/____/_____ mm/dd/yyyy

○ Normal/Benign reaction/Inflammation

○ HPV/Condylomata/Atypia

○ CIN I/mild dysplasia (biopsy diagnosis)

○ ◊ CIN II/moderate dysplasia (biopsy diagnosis)

○ ◊ CIN III/severe dysplasia/CIS or AIS of cervix (biopsy diagnosis)

○ ◊ Invasive Cervical Carcinoma - Squamous Cell or Adenocarcinoma (biopsy diagnosis)

○ Low Grade SIL (biopsy diagnosis)

○ ◊ High grade SIL (biopsy diagnosis)

○ Other - Please specify _____

**◊Treatment status required if final diagnosis is CIN II/CIN III/AIS/HSIL or Invasive Cervical Carcinoma**

## Cervical Cancer Treatment Information

**14a. Treatment Status**

○ Treatment Started

○ Lost to follow-up
(2 calls and certified letter sent)

○ Treatment Refused

○ Treatment Not Needed

○ Died before treatment started

**14b. Date of Treatment Status:**

____/____/_____ mm/dd/yyyy

**15. □ Patient enrolled in BCCTP. Check this box only if you have completed the BCCTP enrollment process**