DETEC - CERVICAL CANCER SCREENING CYCLE DATA   *CONFIDENTIAL DATA*

Recipient ID# `| | | 9 | A | | | | | | | |`   Date of Birth _____/_____/_____ mm/dd/yyyy

Recipient Name: _____   _____ _____
Last   First   Middle

Provider ID# _____

I Pap Test

1a. PREVIOUS Pap Test?
- O No
- O Yes - Date known
- O Unknown - Woman doesn't know
- O Yes - Date unknown but within last 5 years
- O Unknown - Woman wasn't asked / not recorded
- O Yes - Date unknown but more than 5 years
- O Unknown - Woman refused to answer

1b. Date of PREVIOUS Pap Test
_____/_____
mm   yyyy

2. Reason for CURRENT Pap Test (See Instruction Sheet)
- O Routine Pap test
- O Pap test for management of previous abnormal result
- O✦ Pap test not done - Diagnostic work-up and/or HPV test only
- O✦ Pap test not paid by CDP - Client referred for diagnostics only (Report Pap Test result in Item 7)

✦ Complete diagnostic referral date *(Item 3)*

(See Instruction Sheet)

3.✦Cervical Diagnostic Referral Date
_____/_____/_____ mm/dd/yyyy

4. Date of CURRENT Pelvic Exam
_____/_____/_____
mm   dd   yyyy

5. Specimen Adequacy
- O Satisfactory
- O✓ Unsatisfactory

6. Specimen Type
- O Conventional Smear   O Other
- O Liquid Based   O Unknown

7a. CURRENT Pap Test Result
- O Negative for intraepithelial lesion or malignancy
- O✓ Atypical squamous cells of undetermined significance (ASC-US)
- O✓ Low grade SIL (LSIL) - including HPV changes
- O✱ Atypical squamous cells cannot exclude HSIL (ASC-H)
- O✱ High grade SIL (HSIL)
- O✱ Squamous Cell Carcinoma
- O✱ Abnormal Glandular Cells (AGC)
- O✱ AGC - Neoplastic
- O✱ Adenocarcinoma In Situ (AIS)
- O✱ Adenocarcinoma
- O Other - Please specify _____

✱ Immediate work-up needed *(Item 9)*
✓ Short term follow-up recommended *(Item 9)*

7b. Date of CURRENT Pap Test
_____/_____/_____
mm   dd   yyyy

8a. CURRENT HPV Test Result
- O Test Not Done   (See Instruction Sheet)
- O Positive
- O Negative

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

II Additional Procedures Needed to Complete Cervical Cycle?

9.
- O Not needed or planned - **Routine rescreen** (Resume annual screenings)
- O✓ Not needed or planned - **Short term follow-up** (Next appointment planned in less than 12 months)
- O✱ Needed or planned - **Immediate work-up** (Immediate diagnostic work-up is planned)

III Cervical Diagnostic Procedures   · All dates below must be **ON** or **AFTER** the **Date of CURRENT Pap Test** ·

10a. Type of Procedure   (▲ *Covered with restrictions* ▼ *Not Covered by CDP:EWC*) (See Instruction Sheet)
- O Colposcopy without Biopsy
- O Colposcopy with Biopsy and/or ECC
- O▼ Loop Electrosurgical Excision Procedure (LEEP)
- O▼ Cold Knife Cone (CKC)
- O▲ Endocervical Curettage alone (ECC)

10b. Date of Procedure
_____/_____/_____   _____/_____/_____   _____/_____/_____
_____/_____/_____   _____/_____/_____   _____/_____/_____
_____/_____/_____   _____/_____/_____   _____/_____/_____
_____/_____/_____   _____/_____/_____   _____/_____/_____
_____/_____/_____   _____/_____/_____   _____/_____/_____
mm   dd   yyyy   mm   dd   yyyy   mm   dd   yyyy

11a. Other Cervical Procedure Performed   (▲ *Covered with restrictions* ▼ *Not Covered by CDP:EWC*) (See Instruction Sheet)
- O▲ Excision of endocervical polyps
- O▲ Endometrial biopsy (EMB)
- O▼ Biopsy of other structure (e.g., vagina, vulva)
- O Other gynecologic consults
- O Other - Please specify _____

11b. Date of Procedure
_____/_____/_____
mm   dd   yyyy

IV Cervical Work-up Status and Final Diagnosis Information

12a. Work-up Status   (See Instruction Sheet)
- O Work-up complete
- O Lost to follow-up (Two phone calls and certified letter sent)
- O Work-up refused (Patient refused, obtained insurance, moved, or changed PCP)
- O Died before work-up complete

12b. Date of Work-up Status
_____/_____/_____
mm   dd   yyyy

13a. Final Diagnosis
- O Normal / Benign reaction / inflammation
- O HPV / Condylomata / Atypia
- O CIN I / mild dysplasia (biopsy diagnosis)
- O▶ CIN II / moderate dysplasia (biopsy diagnosis)
- O▶ CIN III / severe dysplasia / CIS or AIS of cervix (biopsy diagnosis)
- O▶ Invasive Cervical Carcinoma - Squamous Cell or Adenocarcinoma (biopsy diagnosis)
- O Low grade SIL (biopsy diagnosis)
- O▶ High grade SIL (biopsy diagnosis)
- O Other - Please specify _____

▶ Treatment Status required if final diagnosis is CIN II, CIN III / CIS / AIS, HSIL or Invasive Cervical Carcinoma *(Item 14)*

13b. Date of Final Diagnosis
_____/_____/_____
mm   dd   yyyy

V Cervical Cancer Treatment Information

14a. Treatment Status
- O Treatment started
- O Lost to follow-up (Two phone calls and certified letter sent)
- O Treatment refused
- O Treatment not needed
- O 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.**

Clinician's Signature (optional)_____ **Date** _____

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