Client Identification

Program # __ __ __
ID # __ __ __ __ __ __ __ __ __ __
Visit Date: __ __ / __ __ / __ __ __ __
(Earliest of 10a, 11a, 12a below) *(mm / dd / yyyy)*
☐ *Limited* ☐ *Comprehensive*
Last Name _____
First Name _____
Middle Initial _____
Facility # ___ ___ ___ ___ ___
ANSI # ___ ___ ___ ___ ___
NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Client History

1. Were there any breast changes reported by the woman?
◯ 1. Yes ◯ 2. No ◯ 3. Unknown

2. Has the woman ever had a mammogram?
◯ 1. Yes → 2a. Date previous:__ __ / __ __ __ __
(month/year: Enter 06 if month unknown)
◯ 2. No
◯ 3. Unknown

3. Has the woman ever had a pap test?
◯ 1. Yes → 3a. Date previous:__ __ / __ __ __ __
(month/year: Enter 06 if month unknown)
◯ 2. No
◯ 3. Unknown

Screening Measurements

4. Height __ __ inches
5. Weight __ __ __ pounds
6. Waist Circumference __ __ inches
7. Hip Circumference __ __ inches
◯ Unable to obtain
8. Blood Pressure ***(two readings required):***
8a. 1st Reading: __ __ __ / __ __ __ mmHg
8b. 2nd Reading: __ __ __ / __ __ __ mmHg
***Avg. value > 180/or/110 needs immediate workup**
◯ Unable to obtain
9. Measurement Date: __ __/ __ __ / __ __ __ __
(mm / dd / yyyy)

Examination	Date Performed/Type	Result	Payer
10. **Clinical Breast Exam** ◯ 1. Performed → ◯ 2. Not performed ◯ 3. Refused	10a. *CBE Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*	10b. *CBE Result* ◯ 1. Normal or benign (including fibrocystic, lumpiness, or nodularity) ◯ ***2. Abnormality—suspicious for cancer**	10c. *CBE paid by* ◯ 1. BCCEDP ◯ 2. Other ◯ 3. Unknown ◯ 4. BCCEDP / Insurance ◯ 5. Insurance Only
11. **Mammogram** ◯ 1. Performed; routine screening mammogram → ◯ 2. Performed to evaluate symptoms, positive CBE, or previous abnormal mammogram → ◯ 3. Performed, not paid by BCC; patient referred for DX Evaluation: → *DX referral date:* __ __ / __ __ / __ __ __ __ ◯ 4. Not performed ◯ 5. Refused	11a. *Mamm. Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)* 11b. *Mamm. Type* ◯ 1. Analog ◯ 2. Digital	11c. *Mammogram Result* ◯ 1. Negative (BI-RADS 1) ◯ 2. Benign (BI-RADS 2) ◯ 3. Probably benign—short interval follow-up indicated (BI-RADS 3) ◯ ***4. Suspicious abnormality— consider biopsy (BI-RADS 4)** ◯ ***5. Highly suggestive of malignancy (BI-RADS 5)** ◯ ***6. Assessment incomplete—need additional imaging evaluation (BI-RADS 0)** ◯ ***7. Film comparison required (BI-RADS 0)**	11d. *Mamm paid by* ◯ 1. BCCEDP ◯ 2. Komen ◯ 3. Other ◯ 4. Unknown ◯ 5. BCCEDP / Insurance ◯ 6. Insurance Only
12. **Pap Test** ◯ 1. Performed; routine pap test → ◯ 2. Performed; patient under surveillance for previous abnormal test → ◯ 3. Performed, not paid by BCC; patient referred for DX Evaluation: → *DX referral date:* __ __ / __ __ / __ __ __ __ ◯ 4. Not performed ◯ 5. Refused	12a. *Pap Test Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)* 12b. *Pap Specimen Type* ◯ 1. Conv. Smear ◯ 2. Liquid Based ◯ 3. Other ◯ 4. Unknown	12c. *Pap Specimen Adequacy* ◯ 1. Satisfactory ◯ 2. Unsatisfactory (retest indicated) 12d. *Pap Test Result* ◯ 1. Negative ◯ 2. ASC-US ◯ ***3. Low grade SIL (including HPV changes)** ◯ ***4. ASC-H** ◯ ***5. High grade SIL** ◯ ***6. Squamous cell carcinoma** ◯ ***7. Abnormal glandular cells (including atypical endocervical adenocarcinoma in situ and adenocarcinoma)** ◯ 8. Other_____	12e. *Pap paid by* ◯ 1. BCCEDP ◯ 2. Other ◯ 3. Unknown ◯ 4. BCCEDP / Insurance ◯ 5. Insurance Only
13. **HPV Test** ◯ 1. Performed → ◯ 2. Not performed ◯ 3. Refused	13a. *HPV Test Date* __ __ / __ __ / __ __ __ __ *(mm / dd / yyyy)*	13b. *HPV Test Result* ◯ 1. Positive ◯ 2. Negative ◯ 3. Unknown ◯ 4. Pending	13c. *HPV paid by* ◯ 1. BCCEDP ◯ 2. Other ◯ 3. Unknown ◯ 4. BCCEDP / Insurance ◯ 5. Insurance Only

Follow-up Plan

*** Immediate Diagnostic Testing Indicated**

14. Breast diagnostic workup planned? ◯ 1. Yes ◯ 2. No
15. Breast short-term (less than 9 months) visit recommended? ◯ 1. Yes ◯ 2. No
→ 15a. Breast short-term visit date: __ __ / __ __ __ __ *(mm/yyyy)*
16. Cervical diagnostic workup planned? ◯ 1. Yes ◯ 2. No
17. Cervical short-term (less than 9 months) visit recommended? ◯ 1. Yes ◯ 2. No
→ 17a. Cervical short-term visit date: __ __ / __ __ __ __ *(mm/yyyy)*
18. **Alert** Blood Pressure workup planned? ◯ 1. Yes ◯ 2. No ◯ 3. Follow-up—workup by alternate provider ◯ 4. Refused
19. **Abnormal** Blood Pressure follow-up recommended? ◯ 1. Yes ◯ 2. No
→ 19a. Abnormal follow-up date: __ __ / __ __ __ __ *(mm/yyyy)*