# Breast & Cervical Health Check

## Cervical Cancer Diagnostic Evaluation & Data Collection Form

| Clinic: | Medical Record #: | |
|---|---|---|
| Last Name: | First Name: | MI: |
| Social Security #: | Date of Birth: - - | |

## DIAGNOSTIC PROCEDURE RESULTS

### Repeat Pap/HPV Test

☐ Recommended but refused

☐ Performed, date _____-_____-_____

Type: ☐ Conventional Smear
☐ Liquid Based ☐ Other

Pap result:*
☐ Negative
☐ ASC-US
☐ ASC-H
☐ LSIL Includes HPV changes
☐ HSIL Includes CIS
☐ Squamous Cell Cancer
☐ AGC (Atypical Glandular Cells)
☐ AIS (Endocervical Adenocarcinoma In Situ)
☐ Adenocarcinoma
☐ Unsatisfactory for evaluation

**HPV** high risk panel test:*
Test done on _____-_____-_____ with result:
☐ Negative
☐ Positive

### Colposcopy

☐ Recommended but refused
☐ Performed, date _____-_____-_____

Biopsy not taken, results:
☐ WNL/negative
☐ Inflammation/HPV changes
☐ Other abnormality
☐ Unsatisfactory

Biopsy taken, results:*
☐ WNL/negative
☐ HPV OR ☐ Other nonmalignant abnormality
☐ CIN 1/mild dysplasia
☐ CIN 2/moderate dysplasia
☐ CIN 3/severe dysplasia/CIS
☐ Adenocarcinoma
☐ Invasive Carcinoma

ECC Results:*
☐ WNL/negative
☐ CIN 1/mild dysplasia
☐ CIN 2/moderate dysplasia
☐ CIN 3/severe dysplasia/CIS
☐ HPV or other nonmalignant abnormality
☐ Adenocarcinoma/Glandular Cell Abnormality
☐ Invasive carcinoma
☐ No tissue/unsatisfactory

## DIAGNOSTIC EVALUATION STATUS

**SCREENING SITE CLINICIAN MUST COMPLETE:**

Are any other diagnostic procedures to be performed **as soon as client can be scheduled**?

☐ Yes - Procedure:_____

☐ No – as of _____-_____-_____ the final diagnosis is:

☐ Negative/benign/reactive/inflammation
☐ HPV OR ☐ Other nonmalignant abnormality
☐ CIN 1/mild dysplasia
☐ CIN 2/moderate dysplasia
☐ CIN 3/severe dysplasia/CIS
☐ Invasive cervical cancer

**OR**

☐ Client refused to complete diagnostic work-up
☐ Client is lost to follow-up
☐ Client is deceased

## TREATMENT STATUS or OTHER COMPLETED PROCEDURES

**Treatment started:**
☐ LEEP _____-_____-_____ ☐ Hysterectomy_____-_____-_____
☐ Cryosurgery_____-_____-_____ ☐ Conization _____-_____-_____
Other procedures:
☐ GYN Consult_____-_____-_____ ☐ Other biopsy_____-_____-_____
No treatment as of _____-_____-_____ because client:
☐ Is lost to treatment ☐ Refuses treatment ☐ Is deceased

## MONITORING/SURVEILLANCE

☐ Short term follow up procedure: _____,
on _____-_____ (mo/yr)

☐ Return to screening on _____-_____ (mo/yr)

*** Can send laboratory report, or direct laboratory to send report to BCHC**

State of Alaska, BCHC, 4701 Business Park Blvd., Bldg. J Suite 20, Anchorage, AK 99503-7123
Fax (907) 269-3414