SCREENING FORM
ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

PERSONAL DATA

Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: ____ / ____ / _____ (mm) (dd) (yyyy)

Address: _____

_____ (City) _____ (State) _____ (Zip) Day Phone: (_____) _____

Social Security Number: _____ - _____ - _____ Today's Date: ____ / ____ / _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic Referral Source: ❑ Self ❑ Other ❑ Provider ❑ Outreach ❑ ABCCP reminder

Race (Check all that apply): ❑ White ❑ Black ❑ Asian ❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native

Discussed need to RTC for annual exam? _____ Yes Smoker? _____ Yes (Refer Hot Line 1-800-784-8669)
Case Management Services Needed? _____ Yes (Contact your Area Screening Coordinator)
Does patient have disabilites that could prevent or hinder her from receiving breast or cervical cancer screening services? _____ Yes
List: _____
If woman >50 years of age, has the patient ever had a colonoscopy or any kind of colorectal cancer screening?
❑ Yes ❑ No ❑ Don't know ❑ Didn't ask

BREAST SCREENING DATA

Check here if this is a family planning woman: _____ Yes

Clinic/Provider _____

Prior Mammogram? ❑ Yes, Date: ____ / ____ / _____ ❑ No
Breast Symptoms? ❑ Yes ❑ No
Previous breast cancer? ❑ Yes ❑ No

CBE Results: **Date of CBE:** ____ / ____ / _____
❑ **Normal**
❑ **Benign findings,** NOT suspicious for cancer
❑ *** Discrete palpable mass,** suspicious for cancer
❑ *** Bloody or serous nipple discharge** (not green, black, or white)
❑ *** Nipple or areolar scaliness**
❑ *** Skin dimpling or retraction**
*** Requires surgeon referral or ultrasound**
(use ABCCEDP Breast Diagnostic and Follow-Up Form)

Indication for initial mammogram:
❑ Routine Screening Mammogram
❑ Diagnostic Mammogram or short-term follow-up mammogram
❑ Unknown
❑ Initial mammogram not done, patient proceeded directly for other imaging and diagnostic work up (ex: ultrasound, consultation)
❑ Initial mammogram done by a nonprogram funded provider, patient referred in for diagnostic evaluation;
Date of Breast Diagnostic referral ____ / ____ / _____
Result of mammogram (non-program funded):
_____

Surgical Consult to: _____
Appt. Date: ____ / ____ / _____

CERVICAL SCREENING DATA

Check here if this is a family planning woman: _____ Yes

Clinic/Provider _____

Prior Pap Smear ❑ Yes, Date: ____ / ____ / _____ ❑ No
Hysterectomy? ❑ Yes, Date: ____ / ____ / _____ ❑ No
Reason ❑ Cervical Cancer ❑ Other
Cervix Present? ❑ Yes ❑ No
Post Menopause ❑ Yes ❑ No
ABCCEDP will reimburse for Pap smear after a hysterectomy if:
Hysterectomy was due to Cervical Cancer **or if**
Hysterectomy was due to Other Reasons and Patient still has cervix.

Pelvic Exam Result: Date: ____ / ____ / _____
❑ Normal
❑ Abnormal - NOT suspicious for cervical cancer
❑ Abnormal - suspicious for cervical cancer

High-risk screening, annual pap smear (reason for performing - must be documented in patient chart):
❑ Infection with Human Immunodefciency virus (HIV)
❑ Immuno-suppressed (such as those with renal transplants)
❑ Diethylstilbestrol (DES) exposure in utero
❑ Previously treated for CIN II, CIN III, or cervical cancer found on colposcopic directed biopsy or on a LEEP/Cone procedure

HPV Test Date: ____ / ____ / _____
HPV Result: ❑ Negative ❑ * Positive ❑ Unknown

Indication for Pap Test: Date: ____ / ____ / _____
❑ Routine Pap Test
❑ Patient under surveillance for a previous abnormal test
❑ Unknown
❑ No Pap Test, patient proceeded directly for diagnostic work up or HPV Test
❑ Pap Test done by a non-program funded provider, patient referred in for diagnostic evaluation;
Date of Cervical Diagnostic Referral ____ / ____ / _____
Pap Smear Result _____

Specimen Adequacy: ❑ Satisfactory ❑ Unsatisfactory
Specimen Type: ❑ Slide ❑ Liquid
Pap Smear Result:
❑ **Negative for intraepithelial Lesion or Malignancy**
❑ **ASC-US**
❑ *** ASC-H**
❑ *** LSIL**
❑ *** HSIL**
❑ *** Squamous Cell Carcinoma**
❑ *** AGC**
❑ **Other** _____

* **Diagnostic work-up planned for cervical dysplasia or cancer** (use ABCCEDP Cervical Diagnostic and Follow-Up Form)
GYN Consult to: _____ Appt. Date: ____ / ____ / _____