



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

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Tracking Number (required)

PERSONAL DATA

Name: _____ Date of Birth: _____
 Address: _____ 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
 Patient's Annual Household Income before Taxes: _____ Number of People Living on the Income: _____
 Patient navigation services provided? Yes Smoker? Yes (Refer Hot Line 1-800-784-8669)
 Case Management Services Needed? Yes (Contact your Area Screening Coordinator) Has the patient ever had a colonoscopy or any kind of colorectal cancer screening (If woman >50 years of age)? 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

<p>CBE Results: Date of CBE: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Benign findings, NOT suspicious for cancer <input type="checkbox"/> *Discrete palpable mass, suspicious for cancer <input type="checkbox"/> *Bloody or serous nipple discharge (not green, black, or white) <input type="checkbox"/> *Nipple or areolar scaliness <input type="checkbox"/> *Skin dimpling or retraction *Requires surgeon referral or ultrasound (use ABCCEDP Breast Diagnostic and Follow-Up Form)</p>	<p>Indication for initial mammogram: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic <input type="checkbox"/> No mammogram <input type="checkbox"/> Non-program mammogram, referred in for diagnostic evaluation; Breast Diagnostic referral date: _____ Mammogram result (non-program funded): _____</p>	<p>Risk for breast cancer: <input type="checkbox"/> Average risk <input type="checkbox"/> High /Increased risk* (If yes, check all that apply): <input type="checkbox"/> Women with BRCA mutation <input type="checkbox"/> Has a first degree relative (ex: mom, sister) who is BRCA carrier <input type="checkbox"/> Life time risk of >20% as defined by risk assessment models** <input type="checkbox"/> Had radiation treatment to the chest between ages 10-30 <input type="checkbox"/> Personal history of genetic syndromes like Li-Fraumeni Syndrome</p>
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Surgical Consult to: _____ **Appt. Date:** _____

*Patient may qualify for screening MRI. Prior authorization required to order MRI. Contact your Regional Coordinator for MRI prior approval; Use Breast MRI Authorization and Results Form.
 **Lifetime risk of >20% as defined by risk assessment models (for women 35+: www.cancer.gov/bcrisktool/ and for women under 35 use: www.crahealth.com/risk-express)

CERVICAL SCREENING DATA

Check here if this is a family planning woman: Yes

Clinic/Provider: _____

<p>Prior Pap Smear <input type="checkbox"/> Yes, Date: _____ <input type="checkbox"/> No Hysterectomy? <input type="checkbox"/> Yes, Date: _____ <input type="checkbox"/> No Reason <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Other Cervix Present? <input type="checkbox"/> Yes <input type="checkbox"/> 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.</p>	<p>Risk for Cervical Cancer: <input type="checkbox"/> Average risk <input type="checkbox"/> High risk/increased risk; patient can be screened for annual Pap smear (check all that apply): <input type="checkbox"/> Infection with Human Immunodeficiency Virus <input type="checkbox"/> Immuno-suppressed (such as those with renal transplants) <input type="checkbox"/> Diethylstilbestrol (DES) exposure in utero <input type="checkbox"/> Previously treated for CINII, CINIII or cervical cancer found on colposcopic directed biopsy or on a LEEP/cone procedure</p>	<p>Pap Test Result: <input type="checkbox"/> Negative for intraepithelial lesion or malignancy <input type="checkbox"/> Infection/Inflammation/Reactive Changes <input type="checkbox"/> ASC-US <input type="checkbox"/> *Low Grade SIL <input type="checkbox"/> *High Grade SIL <input type="checkbox"/> *ASC-H <input type="checkbox"/> *Squamous Cell Carcinoma <input type="checkbox"/> *Atypical Glandular Cells <input type="checkbox"/> *Adenocarcinoma in situ (AIS) <input type="checkbox"/> *Adenocarcinoma <input type="checkbox"/> Other</p>
<p>Indication for Pap Test: Date: _____ <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance <input type="checkbox"/> Pap after primary HPV+ <input type="checkbox"/> No Pap Test <input type="checkbox"/> Non-program Pap, referred in for diagnostic evaluation; Date of Cervical Diagnostic Referral _____ Pap Smear Result _____</p>	<p>Indication for HPV Test: <input type="checkbox"/> Co-Test/Screening <input type="checkbox"/> Reflex <input type="checkbox"/> Test not done</p>	<p>HPV test date: _____ HPV Result: <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive with genotyping not done/Unknown <input type="checkbox"/> Positive with positive genotyping (types 16 or 18) <input type="checkbox"/> Positive with negative genotyping (+HPV, but not types 16 or 18)</p>

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

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