CERVICAL DIAGNOSTIC AND FOLLOW-UP FORM
ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

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

Social Security Number:_____ Referring Clinic /Provider:_____

Gynecologist:_____ Phone No:_____ Appointment Date:_____ / _____ / _____

Reason For Referral:_____ Pap Result:_____ Date Performed:_____/ _____ / _____

Insurance Status: ☐ No Insurance ☐ Underinsurance ☐ Insured Billed to Medicaid:_____ Yes

❑ Gynecologic Consultation ❑ Colposcopy no biopsy

❑ Diagnostic Col Knife Cone ❑ Colposcopy with biopsy and/or ECC

❑ Diagnostic ECC ❑ Diagnostic LEEP Date Performed:_____ / _____ /_____

❑ Other_____ Provider:_____

Final Diagnosis Date Performed:_____ / _____ / _____

❑ Normal/Benign/Inflammation

❑ HPV/Condylomata/Atypia

❑ CIN I/Mild Dysplasia

❑ CIN II/Moderate Dysplasia*

❑ CIN III/Severe Dysplasia/Carcinoma Insitu/Adenocarcinoma Insitu*

❑ Invasive Cervical Carcinoma*

Other Abnormalities

❑ Cervical Polyps

❑ VAIN – Vaginal Intraepithelial Neoplasia

❑ VIN – Vulvar intraepithelial Neoplasia

❑ Other_____

*Please contact your Area Screening Coordinator as soon as a cancer or pre-cancer diagnosis is known.

Status of Diagnostic Work-Up

❑ Work-up completed ❑ Work-up pending

❑ Lost to follow-up ❑ Irreconcilable* Date Performed:_____ / _____ / _____

❑ Work-up refused

*If the provider refers for short-term follow-up instead of following guidelines for diagnostic work-up.

Treatment Status

❑ Initiated ❑ Refused

❑ Pending ❑ Not indicated Date Performed:_____ / _____ / _____

❑ Lost to follow-up ❑ Updated (follow-up information)

Treatment (not paid by Alabama Breast and Cervical Cancer Program)

❑ Cryotherapy

❑ LEEP

❑ Laser Therapy Treatment Date:_____ / _____ / _____

❑ Cone Biopsy Treatment Provider:_____

❑ Hysterectomy

❑ Other_____

Please Contact your Area Screening Coordinator to initiate Medicaid application if patient is eligible for the treatment Program.

Case Management Needed ❑ Yes, Contact your Area Screening Coordinator

Further Treatment Required:

Referred to:_____ Phone No:_____ Appt. Date:_____ / _____ / _____

ABCCEDP does not pay for treatment, but the patient may be eligible for Medicaid Treatment Program.