



BREAST AND CERVICAL CANCER CONTROL PROGRAM (BCCCP)

SCREENING FORM - Office Visits

Patient Last Name _____ First Name _____ Birth Date _____

Enrollment Site/Clinic Name: _____ Facility/Provider Name _____

ANNUAL OFFICE VISIT (> 365 days from previous office visit)	SCREENING MAMMOGRAM	PAP TEST (according to guidelines below)
<input type="checkbox"/> Office Visit B – breast services (CBE only) <input type="checkbox"/> Office Visit C – cervical services (Pelvic Exam and/or Pap test) <input type="checkbox"/> (Default) Office Visit B – for both breast and cervical services (CBE/Pelvic Exam and/or Pap Test)	> 365 days from previous screening	<ul style="list-style-type: none"> • Every 5 years with HPV and cytology co-testing (preferred) • Every 3 years with Pap test alone (conventional or liquid based cytology acceptable) • Annual Pap test for history of invasive cervical cancer or if immunocompromised

CLINICAL BREAST EXAM: Date of Visit _____ Result obtained from non BCCCP Provider

R	CBE Results	L	Type of Follow-up	Procedures Ordered?	Date	Location
<input type="checkbox"/>	No Breast Abnormality	<input type="checkbox"/>	None	<input type="checkbox"/> Screening Mammogram		
<input type="checkbox"/>	Benign Breast Condition	<input type="checkbox"/>	None	<input type="checkbox"/> Screening Mammogram		
<input type="checkbox"/>	Probably Benign	<input type="checkbox"/>	<input type="checkbox"/> None <input type="checkbox"/> Short-term	<input type="checkbox"/> Screening Mammogram or <input type="checkbox"/> Diagnostic Mammogram		
<input type="checkbox"/>	Abnormal Breast Exam _____ Dominant mass _____ Nipple Discharge _____ _____ Asymmetric Thickening/ Nodularity _____ Skin Changes _____ _____ Other _____	<input type="checkbox"/>	Immediate (within 60 days)	<input type="checkbox"/> Diagnostic Mammogram (in addition to one or both of the following) <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Surgical Consult <input type="checkbox"/> Other _____		
<input type="checkbox"/>	Not indicated/Omitted	<input type="checkbox"/>	None	None		
<input type="checkbox"/>	Indicated/not performed/declined	<input type="checkbox"/>				
<input type="checkbox"/>	Breast Removed	<input type="checkbox"/>				

PELVIC EXAM Date of Visit _____ Result obtained from non BCCCP Provider

Has Client had a hysterectomy? NO YES If Yes, Date Performed _____ Reason _____

Pelvic exam Not Indicated, Omitted (Reason) _____ Indicated but not performed, Patient refused

Pelvic Exam Results	Type of Follow-up	Pap Test Obtained?
<input type="checkbox"/> Normal, cervix present	None	<input type="checkbox"/> Yes, eligible per BCCCP guidelines <input type="checkbox"/> No, not eligible per BCCCP guidelines
<input type="checkbox"/> Normal, no cervix (hysterectomy for BENIGN or NON invasive cervical cancer)	None	NOT ELIGIBLE PER BCCCP GUIDELINES
<input type="checkbox"/> Normal, no cervix (hysterectomy for invasive cervical cancer)	Annual Pap (ONLY)	<input type="checkbox"/> Yes, eligible ANNUALLY per BCCCP guidelines
<input type="checkbox"/> Abnormal Exam (possibly related to cervical cancer) Describe _____	Immediate (within 90 days) Specify _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason _____

Additional Comments:

Fax this completed form and ALL follow-up reports to LCA @ 269-373-5362