

KENTUCKY WOMEN'S CANCER SCREENING PROGRAM DATA COLLECTION FORM

The following information must be entered electronically & is **REQUIRED** on ALL women ages 40-64 without third party coverage (Medicaid, Medicare or private health insurance) and are below 250% federal poverty guidelines. For ALL valid codes, please refer to the Administrative Reference and KWCSPP Minimum Data Elements Manual.

Patient Name _____ First M.I. Last PASTE "C Label" HERE SSN: _____ Health Dept. _____	Visit Date: ____/____/____ MM DD YYYY Provider ID# _____ (Service Provider: Please fill out each box on form and retain for 10 years.)																																																												
<p align="center">Section A. Breast Screening History Data</p> Breast Symptoms? (self-reported) () 1. Yes () 2. No Prior Mammogram? () 1. Yes () 2. No If yes, Date: ____/____/____ MM DD YYYY	<p align="center">Section A. Cervical Screening History Data</p> Cervix Present? () 1. Yes () 2. No (Do not report vaginal Pap test data) Prior Pap Test? () 1. Yes () 2. No If yes, Date: ____/____/____ MM DD YYYY																																																												
<p align="center">Section B. Breast Screening Data</p> Clinical Breast Exam (CBE) performed at this visit? Yes, (CBE Results): () 1. Normal () 2. Abnormal CBE Date: ____/____/____ (MMDDYYYY) No, () 3. CBE not needed () 4. CBE needed, but not performed (refused) CBE performed by outside provider or other program: () 1. Yes () 2. No If yes, Date Referred into KWCSPP: ____/____/____ MM DD YYYY Mammogram Ordered at this visit? () 1. Yes, Routine screening mammogram ordered () 2. Yes, Screening mammogram ordered (includes short term follow-up) () 3. Yes, Diagnostic mammogram ordered (includes short term follow-up) () 4. No, Mammogram not performed (referred for other diagnostic services)* *Date Referred: ____/____/____ (MMDDYYYY) () 5. No, Mammogram is not performed Mammogram performed by outside provider or other program: () 1. Yes () 2. No If yes, Date Referred into KWCSPP: ____/____/____ MM DD YYYY	<p align="center">Section B. Cervical Screening Data</p> Pap test performed at this visit? () 1. Yes, Routine Pap test is performed () 2. Yes, Pap test is performed (includes short term follow-up Pap test) () 3. No, Pap test is not performed (proceeded directly for HPV testing or diagnostic work-up) () 4. No, Pap test is not performed (includes refused) Pap test performed by outside provider or other program: () 1. Yes () 2. No If yes, Date Referred into KWCSPP: ____/____/____ MM DD YYYY Specimen Adequacy: () 1. Satisfactory () 2. Unsatisfactory Specimen Type: () 1. Conventional Smear () 2. Liquid Based HPV test performed at this visit? () 1. Yes () 2. No If Yes, HPV test date: ____/____/____ MM DD YYYY HPV test result: () 1. Positive () 2. Negative																																																												
<p align="center">Section C. Mammogram Results Data</p> Mammogram Results (BI-RADS): _____ If BI-RADS 0, Prior Film Comparison Required? () 1. Yes () 2. No Date of Mammogram: ____/____/____ (MMDDYYYY) Diagnostic procedures (Work-up) planned: () 1. Yes () 2. No () 3. Not yet determined.	<p align="center">Section C. Pap Test Results Data</p> Pap test results: _____ Pap test date: ____/____/____ MM DD YYYY Diagnostic procedures (Work-up) planned: () 1. Yes () 2. No () 3. Not yet determined																																																												
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<p align="center">Section E. Breast Diagnostic/Follow-up Data</p> 1. Status of Breast Diagnosis: () 1. Work-up complete* () 2. Work-up pending () 3. Lost to follow-up* () 4. Work-up refused* *Date of final diagnosis required 2. Date of Final Diagnosis: ____/____/____ MM DD YYYY 3. Final Breast Diagnosis: () 1. Ductal Carcinoma in Situ (Stage 0) () 2. Invasive Breast Cancer () 3. Breast Cancer not diagnosed () 4. Lobular Carcinoma in Situ (Stage 0)	<p align="center">Section E. Cervical Diagnostic/Follow-up Data</p> 1. Status of Cervical Diagnosis () 1. Work-up complete* () 2. Work-up pending () 3. Lost to follow-up* () 4. Work-up refused* *Date of final diagnosis required 2. Date of Final Diagnosis: ____/____/____ MM DD YYYY 3. Final Cervical Diagnosis: () 1. Normal/Benign reaction/Inflammation () 7. Others: (Describe) () 2. HPV/Condylomata/Atypia () 3. CIN I/Mild dysplasia (biopsy diagnosis) () 4. CIN II/Moderate dysplasia (biopsy diagnosis) () 5. CIN III/Severe dysplasia/Carcinoma in Situ (stage 0) () 6. Invasive Cervical Carcinoma (biopsy diagnosis)																																																												

SCREENING

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ABNORMAL FOLLOW-UP

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KENTUCKY WOMEN'S CANCER SCREENING PROGRAM DATA COLLECTION FORM

Patient Name _____ First M.I. Last PASTE "C Label" HERE SSN: _____ Health Dept. _____

KENTUCKY WOMEN'S CANCER SCREENING CASE MANAGEMENT FORM

The following information is **RECOMMENDED** to be collected on ALL women with an Abnormal PAP/CBE/Mammogram regardless of age.

BREAST CANCER RISK FACTORS

Date counseled on breast cancer risks _____ / _____ / _____
 MM DD YYYY

- Female age 40 or older
- 1st degree relative (mother, sister, daughter) with breast cancer prior to age 50
- Personal history of breast cancer
- Personal history of benign breast condition
- Menarche prior to age 12
- Menopause after age 52
- No pregnancies or 1st pregnancy after age 30
- Obesity and/or high fat diet

CERVICAL CANCER RISK FACTORS

Date counseled on cervical cancer risks _____ / _____ / _____
 MM DD YYYY

- History of HPV and/or cervical dysplasia
- Smoker
- Intrauterine exposure to DES
- Intercourse prior to age 18
- History of 3 or more sex partners in lifetime
- Partner with many sex partners or a partner with cervical dysplasia/cancer
- HIV/AIDS positive or
- History of two or more sexually transmitted infections in lifetime
- Other Immuno-compromised condition _____

Date of Annual/Initial Exam: _____ / _____ / _____ Chronic Illnesses _____
 MM DD YYYY

CBE: Normal _____ Abnormal _____ PAP Test: Normal _____ Abnormal _____ Result _____

Date of Mammogram: _____ / _____ / _____ Result: BI-RADS classification or N/A _____
 MM DD YYYY

PATIENT NOTIFICATION OF ABNORMAL RESULTS

- Telephone Call Date & Response _____
- Letter #1 Date & Response _____
- Certified Letter Date & Response _____
- Home Visit Date & Response _____
- Face to Face Date & Response _____

BREAST & PAP DIAGNOSTIC AND TREATMENT PROCEDURES

PROCEDURE	DATE OF PROCEDURE	DATE RECORDS RECEIVED	FINDINGS and FOLLOW-UP PLANS
Diagnostic Mammogram			
Ultrasound			
Surgical or GYN Consult			
Breast Biopsy/Aspiration			
Lumpectomy/Mastectomy			
Chemotherapy/Radiation			
Colposcopy & Biopsy			
Endometrial Biopsy			
Cryotherapy or LEEP			
Cold knife cone/Hysterectomy			

Next PAP Due _____ Next Mammogram Due _____

Nurse Case Manager: _____