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 KWCSP 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.)

SCREENING

Section A. Breast Screening History Data

Breast Symptoms? (self-reported) ( ) 1. Yes ( ) 2. No

Prior Mammogram? ( ) 1. Yes ( ) 2. No **If yes, Date:** _____/____
MM YYYY

Section B. Breast Screening Data

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 KWCSP:** ___/___/____
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 KWCSP:** ___/___/____
MM DD YYYY

Section C. Mammogram Results Data

Mammogram Results (BI-RADS): _____

If BI-RADS 0, was 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.

ABNORMAL FOLLOW–UP

Section D. Breast Diagnostic (Work-up Planned) Procedures

Procedure	Yes	Date	Result
1. Diagnostic Mammogram (Additional Views)			
2. Ultrasound			
3. Film Comparison			
4. Surgical Consult			
5. Fine Needle/ Cyst Aspiration			
6. Breast Biopsy/Lumpectomy			
7. Other Diagnostic procedures			
7a. Other Diagnostic (report CPT code)			
7b. Other Diagnostic (report CPT code)			

Section E. Breast Diagnostic/Follow-up Data

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)

4. Treatment Status:
( ) 1. Treatment started*
( ) 2. Treatment pending
( ) 3. Lost to follow-up*
( ) 4. Treatment refused*
( ) 5. Treatment not needed*
**Date of treatment required*

5. Date of Treatment Status:
_____/_____/_____
MM DD YYYY

SCREENING

Section A. Cervical Screening History Data

Cervix Present? ( ) 1. Yes ( ) 2. No (Do not report vaginal Pap test data)

Prior Pap Test? ( ) 1. Yes ( ) 2. No **If yes, Date:** ___/____
MM YYYY

Section B. Cervical Screening Data

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 KWCSP:** ___/___/____
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

Section C. Pap Test Results Data

Pap test results: _____ **Pap test date:** _____ /_____/_____
MM DD YYYY

Diagnostic procedures (Work-up) planned:

( ) 1. Yes ( ) 2. No ( ) 3. Not yet determined

ABNORMAL FOLLOW–UP

Section D. Cervical Diagnostic (Work-up Planned) Procedures

Procedure	Yes
1. Colposcopy with Biopsy and/or ECC	
2. Colposcopy without Biopsy	
3. Loop Electrode Excision Procedure (LEEP)	
4. Endocervical Curettage alone (ECC)	
5. Cold Knife Cone	
6. GYN Consult	
7. Others Diagnostic procedures	
7a. Other Diagnostic (report CPT code)	
7b. Other Diagnostic (report CPT code)	

Section E. Cervical Diagnostic/Follow-up Data

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. CINI/Mild dysplasia (biopsy diagnosis) _____
( ) 4. CINII/Moderate dysplasia (biopsy diagnosis)
( ) 5. CINIII/Severe dysplasia/Carcinoma in Situ (stage 0)
( ) 6. Invasive Cervical Carcinoma (biopsy diagnosis)

4. Treatment Status:
( ) 1. Treatment started*
( ) 2. Treatment pending
( ) 3. Lost to follow-up*
( ) 4. Treatment refused*
( ) 5. Treatment not needed*
**Date of treatment required*

5. Date of Treatment Status:
_____/_____/_____
MM DD YYYY

Nurse Case Manager: _____ Date Case Closed:_____ **ACH-58 (Rev. 01/09)**

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: _____