



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: XXX-XX-		Today's Date: _____	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic		Referral Source: ☐ Self ☐ Other ☐ Provider ☐ Outreach ☐ ABCCEDP reminder	
Race (Check all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander			
☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Unknown Smoker? ☐ Yes (Refer Hot Line 1-800-784-8669)			
Patient's Annual Household Income before Taxes: _____		Number of People Living on the Income: _____	

BREAST SCREENING DATA

Check here if this is a family planning woman: ☐ Yes

Clinic/Provider: _____		Prior Mammogram? ☐ Yes, Date: _____ ☐ No	
CBE Results: Date of CBE: _____ ☐ Normal ☐ CBE Not Done ☐ Benign findings, NOT suspicious for cancer ☐ *Discrete palpable mass, suspicious for cancer ☐ *Bloody or serous nipple discharge (not green, black, or white) ☐ *Nipple or areolar scaliness ☐ *Skin dimpling or retraction *Requires surgeon referral or ultrasound (use ABCCEDP Breast Diagnostic and Follow-Up Form)	Indication for Initial Mammogram: ☐ Screening ☐ Diagnostic ☐ No mammogram ☐ Non program mammogram, referred in for diagnostic evaluation; Breast Diagnostic referral date: _____ Mammogram result (non-program funded): _____	Risk for Breast Cancer: (Risk Score: _____ %) ☐ Average risk ☐ High /Increased risk** (If yes, check all that apply): ☐ Women with genetic mutation such as BRCA mutation ☐ Has a first degree relative (ex: mother, sister, daughter) who is BRCA carrier ☐ Had radiation treatment to the chest area before the age of 30 ☐ Personal history of lobular carcinoma in situ ☐ Patient has unusual circumstances to be approved by the Medical Advisory Committee	
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. The risk factors constitute a >20% breast risk assessment score. ANY model can be used, for example, (www.cancer.gov/bcrisktool, <https://ibis-risk-calculator.magview.com/>)

CERVICAL SCREENING DATA

Check here if this is a family planning woman: ☐ Yes

Clinic/Provider: _____		Risk for Cervical Cancer: ☐ Average risk ☐ High risk/increased risk; patient can be screened for annual Pap smear (check all that apply): ☐ Infection with Human Immunodeficiency Virus ☐ Immuno-suppressed (such as those with renal transplants) ☐ Diethylstilbestrol (DES) exposure in utero ☐ Previously treated for CIN II, CIN III or cervical cancer found on colposcopic directed biopsy or on a LEEP/cone procedure		Pap Test Result: ☐ Negative for intraepithelial lesion or malignancy ☐ ASC-US ☐ ***Low Grade SIL ☐ ***High Grade SIL ☐ ***ASC-H ☐ ***Squamous Cell Carcinoma ☐ ***Atypical Glandular Cells ☐ ***Adenocarcinoma in situ (AIS) ☐ ***Adenocarcinoma ☐ Unsatisfactory	
Prior Pap Smear: ☐ Yes: Date or Year: _____ ☐ No ☐ More than 10 years ago Bilateral Tubal Ligation? ☐ Yes ☐ No Hysterectomy? ☐ Yes, Date: _____ ☐ No Reason ☐ Cervical Cancer ☐ Other Cervix Present? ☐ Yes ☐ No Post Menopausal? ☐ Yes ☐ No ABCCEDP will reimburse for pap smear after a hysterectomy if: hysterectomy was due to cervical cancer or if it was due to other reasons and patient still has cervix.		Indication for Pap Test: Date: _____ ☐ Screening ☐ Surveillance ☐ Pap after primary HPV+ ☐ Pap Test Not Done			
Pelvic Exam Result: Date: _____ ☐ Normal ☐ Abnormal - NOT suspicious for cervical cancer ☐ Abnormal - suspicious for cervical cancer		Indication for HPV Test: ☐ Co-Test/Screening ☐ Reflex ☐ Self-Collection (Clinical Setting Only) ☐ Test not done		HPV Result: HPV Test Date: _____ ☐ Negative ☐ Positive with genotyping not done/Unknown ☐ Positive with positive genotyping (types 16 or 18) ☐ Positive with negative genotyping (+HPV, but not types 16 or 18)	
***Diagnostic work-up planned for cervical dysplasia or cancer (use ABCCEDP Cervical Diagnostic and Follow-Up Form)					
GYN Consult to: _____		Appt. Date: _____			
Pap/HPV Follow-Up per ASCCP Guidelines					
Repeat: ☐ 1 year ☐ 3 years ☐ 5 years					