SCREENING FORM
ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

PERSONAL DATA

Name: _____ Date of Birth: _____

Address: _____

_____ Day Phone: _____

Social Security Number: _____ Today's Date: _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic Referral Source: ❑ Self ❑ Other ❑ Provider ❑ Outreach ❑ ABCCP reminder

Race (Check all that apply): ❑ White ❑ Black ❑ Asian ❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native

Patient's Annual Household Income before Taxes: _____ Number of People Living on the Income: _____

Patient navigation services provided? ❑ Yes	Smoker? ❑ Yes (Refer Hot Line 1-800-784-8669)
Case Management Services Needed? ❑ Yes (Contact your Area Screening Coordinator)	Has the patient ever had a colonoscopy or any kind of colorectal cancer screening (If woman >50 years of age)? ❑ Yes ❑ No ❑ Don't know ❑ Didn't ask

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**
❑ **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
❑ Personal history of breast cancer
❑ High /Increased risk* (If yes, check all that apply):
- ❑ Women with BRCA mutation
- ❑ Has a first degree relative (ex: mom, sister) who is BRCA carrier
- ❑ Life time risk of >20% as defined by risk assessment models**
- ❑ Had radiation treatment to the chest between ages 10-30
- ❑ Personal history of genetic syndromes like Li-Fraumeni Syndrome

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.
**Lifetime risk of >20% as defined by risk assessment models (for women 35+: www.cancer.gov/bcrisktool/ and for women under 35 use: www.crahealth.com/risk-express)

CERVICAL SCREENING DATA

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

Clinic/Provider: _____

Prior Pap Smear ❑ Yes, Date: _____ ❑ No
Hysterectomy? ❑ Yes, Date: _____ ❑ No
Reason ❑ Cervical Cancer ❑ Other
Cervix Present? ❑ Yes ❑ No

ABCCEDP will reimburse for Pap smear after a hysterectomy if: Hysterectomy was due to Cervical Cancer **or if** Hysterectomy was due to Other Reasons and Patient still has cervix.

Indication for Pap Test: Date: _____
❑ Screening ❑ Surveillance
❑ Pap after primary HPV+ ❑ No Pap Test
❑ Non-program Pap, referred in for diagnostic evaluation;
Date of Cervical Diagnostic Referral _____
Pap Smear Result _____

Pelvic Exam Result: Date: _____
❑ Normal
❑ Abnormal - NOT suspicious for cervical cancer
❑ Abnormal - suspicious for cervical cancer

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)
- ❑ Diethystillbestrol (DES) exposure in utreo
- ❑ Previously treated for CINII, CINIII or cervical cancer found on colposcopic directed biopsy or on a LEEP/cone procedure

Pap Test Result:
❑ Negative for intraepithelial lesion or malignancy
❑ Infection/Inflammation/ Reactive Changes
❑ ASC-US
❑ *Low Grade SIL
❑ *High Grade SIL
❑ *ASC-H
❑ *Squamous Cell Carcinoma
❑ *Atypical Glandular Cells
❑ *Adenocarcinoma in situ (AIS)
❑ *Adenocarcinoma
❑ Other

Indication for HPV Test:
❑ Co-Test/Screening
❑ Reflex
❑ Test not done

HPV test date: _____
HPV Result: ❑ Negative ❑ Unknown
❑ 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: _____