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

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: _____

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

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 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

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**