CERVICAL DIAGNOSTIC AND FOLLOW-UP FORM
ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

Name: _____ Date of Birth: ____ / ____ / _____
(Last) (First) (Middle) (mm) (dd) (yyyy)

Social Security Number: _____-_____-_____ Referring Clinic/Provider: _____

Gynecologist: _____ Phone No:_____ Appointment Date: _____ / _____ / _____

Reason for Referral: _____

Insurance Status: ❑ No Insurance ❑ Underinsurance ❑ Insured | Billed to Medicaid: _____ Yes

❑ Gynecologic Consultation
❑ Diagnostic Cold Knife Cone
❑ Diagnostic ECC
❑ Other _____
❑ Colposcopy no biopsy
❑ Colposcopy with biopsy and/or ECC
❑ Diagnostic LEEP

Date Performed: ____ / ____ / _____
Provider: _____

Final Diagnosis

Date Performed: ____ / ____ / _____

❑ Normal/benign/inflammation
❑ HPV/Condylomata/Atypia
❑ CIN I/mild dysplasia
❑ CIN II/moderate dysplasia*
❑ CIN III/severe dysplasia/Carcinoma insitu/Adenocarcinoma insitu*
❑ Invasive Cervical Carcinoma*

Other Abnormalities
❑ Cervical polyps
❑ VAIN - vaginal intraepithelial neoplasia
❑ VIN - vulvar intraepithelial neoplasia
❑ Other _____

* Please contact your Area Screening Coordinator as soon as a cancer or pre-cancer diagnosis is known.

Status of Diagnostic Work-up

❑ Work-up completed
❑ Lost to follow-up
❑ Work-up refused
❑ Work-up pending
❑ Irreconcilable*

Date Performed: ____ / ____ / _____

* If the provider refers for short-term follow-up instead of following guidelines for diagnostic work-up.

Treatment Status

❑ Initiated
❑ Pending
❑ Lost to follow-up
❑ Refused
❑ Not indicated
❑ Updated (follow-up information)

Date Performed: ____ / ____ / _____

Treatment (not paid by Alabama Breast and Cervical Cancer Program)

❑ Cryotherapy
❑ LEEP
❑ Laser Therapy
❑ Cone biopsy
❑ Hysterectomy
❑ Other _____

Treatment Date: ____ / ____ / _____
Treatment Provider: _____

Please contact your Area Screening Coordinator to initiate Medicaid application if patient is eligible for treatment program

Case Management Needed ❑ Yes Contact your area screening coordinator

Further Treatment required:

Referred to: _____ Phone No:_____ Appt. Date: ____ / ____ / _____

ABCCEDP does not pay for treatment, but patient may be eligible for Medicaid Treatment Program.