Part 1, to be completed and sent with enrollment paperwork

Part 2, to be completed and sent after PAP/Mammogram results are received.

BC3NP Breast & Cervical Cancer Control Navigation Program

Breast and Cervical Screening Form

Last Name _____ First Name _____ Birth Date: _ _ / _ _ / _ _ _ _

Enrollment/Clinic Site:	**Office Visit**
Traverse Health Clinic Facility/Provider:	☐ Full–CBE and Pelvic Exam Date: _____ ☐ Partial Breast–CBE/breast services only ☐ Partial Cervical–Pelvic/Cervical services only
Clinical Breast Exam Performed	**Pelvic Exam Performed**
☐ Yes - Date: _____ ☐ Not Indicated/Omitted/Not Done ☐ Client refused	☐ Yes - Date: _____ ☐ Not Indicated/Omitted/Not Done ☐ Client refused

RT	LT	**CBE Results** Non-BC3NP Referral ☐ No ☐ Yes	**Pelvic Exam Results** Non-BC3NP Referral ☐ No ☐ Yes
		Normal / Benign	☐ Normal Exam, Cervix **Present** ☐ Normal Exam, Cervix **Absent**
		Abnormal Exam: Suspicious for Cancer: Refer for diagnostic procedures	☐ **Abnormal Exam, Suspicious for Cervical Cancer:** Refer for diagnostic procedures

Breast Cancer Screening

Breast Imaging Results: Choose the appropriate result (0-8) for **each** imaging test performed.

(0-AI) BIRADS 0: **Assessment Incomplete–Need Additional Imaging**	(4) BIRADS 4: **Suspicious Abnormality**
(0-FC) BIRADS 0: **Assessment Incomplete–Film Comparison**	(5) BIRADS 5: **Suggestive of Malignancy**
(1) BIRADS 1: Negative	(6) BIRADS 6: Known Malignancy
(2) BIRADS 2: Benign Finding	(7) Not Indicated/Omitted/Not Done
(3) BIRADS 3: Probably Benign Finding	(8) No Show/Unable to Locate Client

Mammogram Date: _____ ☐ Screening ☐ Diagnostic Non-BC3NP referral ☐ Yes ☐ No Facility/Provider:	**Ultrasound** Date: _____ Non-BC3NP referral ☐ Yes ☐ No Facility/Provider:	**Screening MRI** Date: _____ Non-BC3NP referral ☐ Yes ☐ No Facility/Provider:

RT Mammogram	LT Mammogram	RT Ultrasound	LT Ultrasound	RT MRI	LT MRI

Breast Follow-up Needed? ☐ No follow-up – Resume annual screening

☐ Short-term (< 6 months) ☐ Diagnostic Mammogram ☐ Ultrasound ☐ Other _____

☐ Immediate (< 2 months) ☐ (Specify) _____

Cervical Cancer Screening

PAP Test Non-BC3NP referral ☐ Yes ☐ No

☐ Negative ☐ Infection/Inflammation/Reactive Changes

☐ ASC-US ☐ LSIL ☐ **ASC-H** ☐ **HSIL**

☐ **Atypical Glandular Cells** ☐ **Squamous Cell Carcinoma**

☐ **Adenocarcinoma** ☐ **Adenocarcinoma in Situ (AIS)**

☐ **Unsatisfactory–Need Repeat Pap (within 4-6 months)**

☐ Unknown–Presumed Abnormal (Referral from Non-BC3NP)

☐ Not Indicated/Omitted/Not Done

☐ No Show/Unable to Locate Client

HPV Test ☐ Co-Test (Screening) ☐ Reflex

☐ Negative

☐ **Positive** (+ Genotyping 16 or 18)

☐ Positive (- Genotyping, not 16 or 18)

☐ **Positive** (Genotyping Not Done)

☐ Unknown

☐ Test Not Done

Cervical Follow-up Needed?

☐ No follow-up – Resume regular screening ☐ Pap alone

☐ Pap/HPV (Co-Test) in _____ years ☐ Pap/HPV (Co-Test) in 1 year

☐ Immediate (< 2 months) ☐ (Specify) _____