

# 2

## SCREENING SERVICES

### A. Enrollment and Screening Duties:

#### 1. Medical Service Provider Enrollment

Cancer control specialists will:

- Solicit and enroll all interested medical service providers in their geographic areas.
- Act as a liaison between the MCCP and the enrolled medical service providers in their geographic areas.
- Be responsible for answering providers' questions about client and program issues.
- Conduct an orientation for enrolled medical service providers.
- Submit a signed and completed provider enrollment packet to the address noted on the provider enrollment application.
- Ensure providers follow the Centers for Disease Control and Prevention (CDC) guidelines for comprehensive cancer screening.
- Ensure providers provide referral to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP) if necessary.

#### 2. Client Enrollment

An enrollment span is a one-year period during which a client may be screened for breast, cervical, or colorectal cancer.

Cancer control specialists will:

- Determine whether a person is eligible for services, either by telephone or an in-person interview and which screening service he or she needs. (See Section G.3.)
- Complete the MCCP enrollment forms, ensuring the following:
  - Each client signs an "Informed Consent and Authorization to Disclose Health Care Information."<sup>1</sup> This form must be signed before any services can be provided.
  - Client screening history and risk assessment is completed.
  - Client's tobacco use status is assessed; those who use tobacco are referred to the Montana Quit Line.

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<sup>1</sup> An Informed Consent and Authorization to Disclose Health Care Information is a form signed by the client that allows the sites to collect information about procedures provided to the client by the MCCP for a 6-month period beginning the date of the date on the form. At the end of the 6-month period a new informed consent must be signed or data collection must stop. The data collected in the 6-month period can be shared for 30 months beginning the day of the date on the form.

### 3. American Indian Enrollment

Together with subcontractors, local grassroots coalitions and the statewide Montana American Indian Women's Health Coalition (MAIWHC), cancer control specialists work to increase the number of American Indian individuals being screened through the MCCP per the American Indian Screening Initiative (AISI).

## B. Tracking and Follow-up

### 1. Screening through Diagnosis

The cancer control specialists and enrolled medical service providers share equal responsibility for tracking and follow-up to ensure all clients complete the required diagnostic exams as scheduled.

The cancer control specialist must:

- Implement a referral, tracking and follow-up system covering and documenting a client's initial screening through diagnosis and, if necessary, to initiation of treatment.
- Ensure all clients complete the required diagnostic exams as scheduled and within the required timeframes (see pages 4-3, 5-4 and 6-6).
- Notify a client of test results either by telephone, office visit or mail.
  - Do not use any means of communication that cannot ensure confidentiality.
  - Do not send test results to the client by postcard or fax, e-mail and do not leave results on an answering machine. Verify that the client knows that the address on the enrollment form is where confidential mail will be sent.

### 2. Abnormal Results

Tracking and follow-up requirements for abnormal screening and diagnostic results include:

- Contact the client to discuss the type of follow-up needed or schedule an appointment, and inform the client of:
  - The nature of the suspected disease.
  - The need for further testing or follow-up care.
  - The choices (if available) of referrals for definitive diagnostic procedures after screening procedures have been performed.
  - Their responsibility to obtain follow-up care.
- Indicate on the MCCP screening form that a workup is planned and complete the abnormal screening form.
- Supply any other information requested by the MCCP state office on clients with abnormal test results.
- Document contact with the client's enrolled medical service provider in the client's record.

### 3. Rescreening

Cancer control specialists will notify the client when rescreening is needed. Normal rescreening will occur based on the MCCP guidelines and enrolled medical service provider recommendations.

#### **4. Clients “Lost to follow-up”**

Before considering a client “lost to follow-up” the cancer control specialist must:

- Make three attempts to contact a client. The first two attempts may be by phone or writing. The third or final attempt must be a letter sent by certified mail with a return receipt requested.
- Complete all attempts to contact a client within 6 weeks of receiving notice of abnormal results.
- Indicate on the MCCP data collection forms “lost to follow-up” under “Status of Final Diagnosis” or “Status of Treatment” when a client does not respond to contact attempts regarding the need for further diagnostic tests, initiation of treatment or when a client dies or moves before workup is started.

#### **5. Client Refusal of Follow-up Tests or Treatment**

If a client with an abnormal test result (suspicious for cancer) refuses diagnostic tests or treatment, the “MCCP Acknowledgement of Refusal to Consent to Diagnostic Tests or Treatment” form must be completed by the medical service provider and signed by the client. Cancer control specialists will act as a liaison to the client and provider if necessary.

Indicate on the MCCP data collection forms “Refused” under “Status of Final Diagnosis” or “Status of Treatment” when a client refuses to obtain further diagnostic tests, treatment or severs her relationship with the MCCP.

### **C. Clients Who Move**

#### **1. Within Montana or Out-of-State**

When a client moves, the cancer control specialist will refer the client to the Montana regional contractor or the out-of-state program nearest their new residence; contact the state MCCP office to obtain information for screening programs in other states. It is the client’s responsibility to contact the new site for subsequent services, if needed, and to sign a copy of the “Informed Consent and Authorization to Disclose Health Care Information” form for release of medical information.

The cancer control specialist must:

- Notify the MCCP state office that the client has moved.
- Provide the client with copies of the screening results or obtain the client’s permission in writing to forward screening results as indicated by the client’s request.

## **D. Patient Navigation Services**

Patient navigation is the component of the MCCP which establishes, brokers and maintains the system of clinical services (screening, diagnostic and treatment) and support services to breast and cervical clients. The colorectal component of the MCCP does not have a patient navigation option.

The specific goal of patient navigation is to ensure MCCP clients receive timely and appropriate rescreening, diagnostic and treatment services. The priority population includes clients who have an abnormal breast and/or cervical screening test result or a diagnosis of breast and/or cervical cancer.

Key elements of patient navigation for the MCCP at all levels include:

- Assessment
- Planning
- Coordination
- Monitoring
- Evaluation
- Resource Tracking and Development

The cancer control specialist is responsible for assessing the client's need for patient navigation services and, if necessary, developing and monitoring each client's plan for these services.

Cancer control specialists will:

- **Assess:** Contact the client to assess for patient navigation services within ten (10) working days of receiving the client's abnormal screening test result.
- **Plan:** Implement the "Patient Navigation Service Agreement Plan" within twenty (20) working days of assessing the client's need for patient navigation services, if needed.
- **Coordinate:** Refer clients diagnosed with breast or cervical cancer or pre-cancer to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP).
- **Monitor and Evaluate:** Monitor and update the Patient Navigation Service Agreement Plan weekly until date of final diagnosis or application for the MBCCTP is made and treatment is initiated.
- **Resource Tracking and Development:** Develop a list of available community resources in the multi-county areas. Develop formal and informal agreement with other entities in their multi-county areas to facilitate referrals for diagnostic and treatment services.

## **E. Policy and Protocol to Determine Place of Enrollment**

The client's county of residence determines the contracting region where he/she will be enrolled with the exception of American Indian clients who live on or near Montana reservations. American Indian men and women's county of residence is the region that has direct responsibility for serving the reservation. If a client chooses to go to a region outside the region of his/her residence, that contracting region must send the enrollment forms to the Cancer Control Specialist who covers the area in which the client resides.

## F. MCCP Support to Cancer Control Specialists

### 1. Quality Assurance

- Implement policies and systematic procedures designed to monitor and improve the MCCP.
  - Identify corrective actions to be taken to remedy any problems found in the quality of care provided to the MCCP target population.
- Ensure enrolled medical providers maintain a valid license to practice in Montana.
  - Mammography facilities must be fully certified by the Food and Drug Administration under the Mammography Quality Standards Act of 1992 (MQSA).
  - Cytology facilities must be fully certified by the Food and Drug Administration under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
- Review client screening data to monitor compliance with the MCCP eligibility guidelines.
- Review patient navigation data for compliance to timeliness and resources used.

### 2. Reimbursement

The MCCP will:

- Reimburse enrolled medical service providers for the cost of performing covered services, provided these have been conducted in accordance with the algorithms approved by the MCCP. Clients are responsible for paying for any other services or tests.
- Reimburse all approved medical service providers for allowable claims according to the current approved fee schedule, within the time frames and under the guidelines outlined in the MCCP PPM (chapter 3).
- Ensure that Montana Medical Billing on behalf of the MCCP, will:
  - Receive all medical service provider enrollment packets and ensure all federal and state requirements are met for each provider.
  - Ensure medical service providers meet all insurance, licensure and certification requirements for program services as outlined in the MCCP PPM.
  - Receive and adjudicate all claims and reimbursement data, including review for third party payment, duplication, client eligibility and allowable services.

**Note:** The MCCP is the payer of last resort except for Indian Health Service. The MCCP will provide reimbursement for covered services only if no other source of payment is available to the client. Other available sources of payment include:

- Private insurance (whole or partial payment)
- Medicare
- Medicaid
- Title X Family Planning
- Other local private or public funded programs

This means reimbursement for screening services provided to men and women enrolled in Medicare Part B should be paid by Medicare, not by the MCCP. Medicare Part B is an optional program charging a monthly premium for enrollment. A person who cannot pay the premium to enroll in Medicare Part B and meets the MCCP income eligibility criteria is eligible to receive MCCP services. (See Sections G.3. and G.4.)

### **3. Training and Communication**

The MCCP will:

- Provide training, technical assistance and consultation necessary for the performance of services, including support from MCCP consultants on comprehensive cancer control, community collaboration, public outreach and medical service professional education and support.
- Be readily accessible to the Contractor to discuss program issues.
- Provide electronic access to regular reports to the Contractor, which includes a list of MCCP clients screened in the multi-county area and the status of clinical data as required in the MCCP PPM for these clients.
- Provide a toll-free fax line with which the Contractor may communicate with the program.
- Provide data collection forms, provider enrollment packets, MCCP PPMs updates, program brochures and education materials via [www.cancer.mt.gov](http://www.cancer.mt.gov) to the Contractor.
- Provide telephone and web meetings related to MCCP operations.
- Provide electronic access to the MCCP site data system as applicable for site entry of data collection forms.

## **G. Screening Policies**

### **1. Policy on Screening Guidelines**

The Montana Cancer Control Programs (MCCP) is funded predominately by the Centers for Disease Control and Prevention (CDC). The CDC follows the United States Preventive Services Task Force (USPSTF) which is an independent panel of non-Federal experts in prevention and evidence-based medicine and is composed of primary care providers (such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists).

The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of "Recommendation Statements."

As a grantee of CDC the MCCP adheres to the recommendations of the USPSTF to ensure:

- appropriate screening and follow up for screening program clients
- education for the general public
- education for medical service providers
- only cancers for which there are evidence based screening tests are included (breast, cervical and colorectal)

The MCCP also recognizes there are other guidelines which are equally valuable. Therefore, when working with medical service providers most notably in the screening program, the MCCP encourages an informed discussion between client and provider, taking into account patient context, which includes the client's values regarding benefits and harms of screening options.

Providers enrolled to provide screening services to MCCP clients are reimbursed according to USPSTF cancer screening guidelines.

## 2. Policy on Screening Goals for Breast, Cervical and Colorectal Cancers

### **Breast and Cervical Cancer Screening:**

The Breast/Cervical screening cycle is counted towards the screening goal when at least one of the Breast or Cervical procedures has a 'Yes' in the **Paid by NBCCEDP** field.

The Fiscal Year (FY) in which the Breast/Cervical cycle is counted towards the screening goal is determined by the last procedure date.

The Breast/Cervical screening cycle is not counted towards the Breast/Cervical screening goal when the following criteria are met:

- All breast and cervical procedures have a 'No' in the **Paid by NBCCEDP** field.
- A client already has a Breast or Cervical cycle that has been counted towards the screening goal for a FY. A client is counted only once per FY; any subsequent screening cycles for the same FY are not counted towards the screening goal.

### **Colorectal Cancer Screening:**

The CRC screening goal is broken out by the initial screening procedure performed in the cycle.

The CRC screening cycle is counted towards the CRC screening goal when all of the following criteria are met:

- At least one of the CRC screening procedures in the cycle has a 'Yes' in the **CRCCP Funds Used** field.
- **The final diagnosis status** is one of the following:
  - Complete (final diagnosis made)
  - Refused Diagnostic Follow-Up
  - Lost to Follow-Up before final diagnosis was made

The Fiscal Year (FY) in which the CRC screening cycle is counted towards the screening goal is determined by the **Date of the Final Diagnosis**.

When a CRC screening cycle is not counted towards the CRC screening goal when all of the following criteria are met:

- All colorectal procedures have a 'No' in the **CRCCP Funds Used** field.
- CRC cycles that have Non-Adherence procedures are not counted towards the CRC screening goal.
- A client already has a CRC cycle that has been counted towards the screening goal for a FY. A client is counted only once per FY; any subsequent screening cycles for the same FY are not counted towards the screening goal.

### 3. Policy on Clients Who Have Health Insurance

The Affordable Care Act has mandated specific preventive services be covered for people with a new health insurance plan or insurance policy beginning on or after September 23, 2010. (<https://www.healthcare.gov/preventive-care-benefits> ).

- The Montana Cancer Control Programs (MCCP) will not enroll a person with insurance in the screening component until it is determined that the preventive services are not covered by his/her insurance.
- A client may be considered “under-insured” and eligible for MCCP services if the client has health insurance with co-payments, deductibles, or co-insurance that presents a financial barrier to breast, cervical and/or colorectal cancer screening. A co-payment, deductible or co-insurance of \$500 or greater is considered “under-insured”.
- The person may be enrolled in the MCCP for diagnostic services if eligibility requirements are met and per discretion of Cancer Control Specialist.
- The MCCP is the payer of last resort except for Indian Health Services. The MCCP will provide reimbursement for covered services only if no other source of payment is available to the client.
- The Cancer Control Specialist is responsible for tracking the client’s services and claims to ensure that the MCCP is not charged for services covered by the client’s insurance.

#### Processing a Client with Insurance

If a client meets all the eligibility requirements for enrollment in the program he/she wishes to participate (Breast, Cervical and/or Colorectal Cancer Screening program component) of the Montana Cancer Control Programs (MCCP) and:

- A. The client has health insurance
  1. Have the client call his/her insurance company to verify the coverage he/she has for preventive cancer screening services.
    - a. If the client’s health insurance covers his/her screenings in full:
      - Ask the client to notify you if he/she needs diagnostic services that are not covered by his/her insurance.
      - Hold the client’s enrollment form in the event he/she needs to be enrolled in the program.
    - b. If the client has a diagnostic procedure that isn’t covered by his/her insurance, but is covered by the MCCP then enroll the client.
      - Enter all the breast and/or cervical screening procedures. (CBE, mammogram, Pap test). If they were not done enter a dummy procedure.
      - Enter the diagnostic procedures that were done.
      - Enter No in the paid by NBCCEDP/ CRCCP funds used text box if the procedure was paid in full by the client’s insurance.
      - Enter Yes in the paid by NBCCEDP/ CRCCP funds used text box if the claim was fully or partially paid for by the MCCP program.
- B. The client reports he/she DOES NOT have health insurance but in fact he/she has insurance that covers preventive cancer screening services.
  1. To determine if the client’s claims were paid by insurance or by the MCCP, open the Site Data System and print reports with this information (See below for instructions on printing the report).
  2. Update the data entry.

- Enter No in the paid by NBCCEDP/CRCCP funds used text box if the procedure was paid in full by the client's insurance.
  - Enter Yes in the paid by NBCCEDP/CRCCP funds used if a partial amount or the whole amount was paid for by the MCCP program.
3. If necessary work with the provider and Montana Medical Billing to get a refund if the claim is covered by insurance but paid by MCCP.

To check if a client has had claims paid by the MCCP:  
Open the Site Data System.

- a. Click the Audits Report button, and then click the button labeled MMB Claims Denied Insurance Paid More Than Allowable Amount. The report is a list of clients whose claims were paid by their insurance. The client may or may not have reported having insurance. Use the name of the provider, the date of service, the CPT code and the procedure description to match the claims to the client's procedures in the CaST data system.
- b. Click the Finance and Statistics button, and then click the Claims Patient Inquiry button. Enter the clients name in the blue Name Search combo box. If the claims grid is blank there are no claims for the client entered. If claims are listed, double click on the person's name in the orange square to see the claim detail. Use the name of the provider, the date of service, the CPT code and the amount paid to match the claims to the client's procedures in the CaST data system.

#### **4. Policy on Self-Reporting of Income**

The MCCP screening program is an income self-reporting program. This means that clients are able to report their income when inquiring about enrollment. Based on stated income, a client may or may not be eligible for enrollment.

The MCCP is under no obligation to verify this stated income; nor are contractors encouraged to verify. It is appropriate to discuss any income discrepancies with the client and that income will be verified if enrolling in the Montana Breast and Cervical Cancer Treatment Program. If a client misstates their income and it is later determined they are over income, it is not required to remove them from the program.

Currently there is no legal recourse for the program to deny future screenings to these individuals. However, if slots are not available, the MCCP will not be able to enroll these clients.



### Breast and Cervical Cancer Screening Eligibility Form



#### Eligibility-Enrollment Information

What is your age?	Family's yearly income before taxes?	Number of people in household?		
Last Name	First Name	Middle Initial	Other Last Names Used	
Birth Date	Social Security Number			
Mailing Address	City	State	Zip	County

Phone Numbers (Is it ok to leave messages regarding eligibility/appointments on these phones?  Yes  No )  
 Home Phone number: ( ) - Cell Phone number: : ( ) - E-Mail Address

<b>Ethnic Background</b> Are you Hispanic? (Spanish/Hispanic/Latino) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Race</b> Which race(s) best describe(s) you? <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other/Unknown
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#### Healthcare Coverage

Do you have Medicare Part B?  Yes  No Do you have Medicaid?  Yes  No  
 Do you have health insurance?  Yes  No If Yes, name of Insurance Company \_\_\_\_\_  
 What is the deductible amount? \_\_\_\_\_  
 Have you been referred to the Marketplace for health insurance or Expanded Medicaid Plans?  Yes  No Date Referred \_\_\_\_\_

#### Medical Background

Are you having any breast problems?  Yes  No Have you ever had a Pap test?  Yes  No  
 Have you ever had a mammogram?  Yes  No Date of last Pap test \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_ Have you had a hysterectomy?  Yes  No  Unknown  
 Do you have breast implants?  Yes  No If yes, was it due to cervical cancer?  Yes  No  Unknown  
 Do you have a personal or family history of breast cancer? If yes, do you still have a cervix?  Yes  No  Unknown  
 Yes  No  Unknown

#### Tobacco Use Cessation MT Quit Line: 1-800-QUIT-NOW

**Do you use tobacco?**  Yes  No  
 Yes, and I'm ready to quit and ask that a quit line coach call me. I understand that the MT Quit Line will inform my provider about my participation. If yes, please sign the Montana Tobacco Quit Line Patient Fax Referral Form Authorization to Release Information section on the Informed Consent and Authorization to Disclose Health Care Information page.  
 Yes, but I do not want a quit line coach to call me..

#### How did you hear about the program? (Check all that apply)

Medical Provider (Name of Provider) \_\_\_\_\_  
 Internet  Pink/Purple Card (Pamphlets)  TV  Re-screen/Previously Enrolled  Family/Friend/Word of Mouth  
 Presentation  MAIWHC  Fair-Job/Health or Pow Wow  Special Promotion/ Promotional Ad  Newspapers/Newsletters  
 Government Office  Radio  Other \_\_\_\_\_

Please continue to the next page.



**Client Name:** \_\_\_\_\_

**How Can We Help?**

**Our mission is to improve and protect the health of Montanans by creating conditions for healthy living.**

What health areas would you like assistance with?

**Are there any circumstances that might prevent you from receiving your cancer screening services?**

Please describe those circumstances below, if none, check None

Lack of transportation     Time off from work     None

Other, please describe: \_\_\_\_\_

\_\_\_\_\_

**Do you need assistance with any of the following to access medical services? Check all that may apply or check None.**

- Difficulty with hearing     Difficulty with vision
- Difficulty dressing or bathing
- Difficulty concentrating, remembering or making decisions
- Difficulty with mobility, such as walking or climbing stairs
- Difficulty doing errands such as visiting a doctor's office or shopping
- Other \_\_\_\_\_
- None

**We have resources and information available about the following topics, what are you interested in learning more about?**

- Arthritis Chronic Disease Self-Management
- Diabetes     Asthma     Injury Prevention
- Cardiovascular Health
- Nutrition & Physical Activity
- Other \_\_\_\_\_
- None, not interested.



**Please Read and Sign the Informed Consent and Authorization to Disclose Health Care Information.**

**Office Use Only**                      **State ID** \_\_\_\_\_

Eligibility Determined by: \_\_\_\_\_ Date: \_\_\_\_\_

Prior approval given by: \_\_\_\_\_ Date: \_\_\_\_\_



Please Read and Sign



Client Name: \_\_\_\_\_

### Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana women can be screened through this program for breast and cervical cancers. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

#### Services Not Covered

The MCCP only provides services for breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

#### Insurance Information

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

#### Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

#### Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), the laboratory reading my Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask questions about the MCCP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out of the MCCP at any time.

#### Montana Tobacco QUIT Line - Patient Fax Referral Form Authorization To Release Information

Yes, I am ready to quit and ask that a quit line coach call me. I understand that the Montana Tobacco Quit Line will inform my provider about my participation. **Client Signature:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_

**Print Full Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
MM / DD / YYYY

Client Name	Phone Number	State ID	
Social Security Number	Date of Birth <small>MM / DD / YYYY</small>	Admin Site #	<input type="checkbox"/> Revised

### CERVICAL CANCER SCREEN RESULTS

<p><b>Date of Pap test</b> <u>MM / DD / YYYY</u></p> <p><b>Pap specimen type</b>    <input type="checkbox"/> Liquid    <input type="checkbox"/> Conventional</p> <p><b>Adequacy of Pap specimen</b>    <input type="checkbox"/> Satisfactory    <input type="checkbox"/> Unsatisfactory</p> <p><b>Result of screening Pap test</b></p> <p><input type="checkbox"/> Negative for intraepithelial lesion or malignancy</p> <p><input type="checkbox"/> ASC-US</p> <p><input type="checkbox"/> Low Grade SIL (including HPV changes)</p> <p><input type="checkbox"/> ASC-H</p> <p><input type="checkbox"/> High Grade SIL</p> <p><input type="checkbox"/> Squamous Cell Carcinoma</p> <p><input type="checkbox"/> Abnormal Glandular Cells</p> <p><b>Date of HPV/DNA test</b> <u>MM / DD / YYYY</u></p> <p><b>High Risk HPV/DNA test results if done</b></p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative</p> <p><b>Paid by MCCP</b></p> <p>Pap test    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>HPV/DNA test    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>Respond for ALL clients screened for cervical cancer</b></p> <p><b>Has this client had a hysterectomy?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>If "Yes" was the hysterectomy</b></p> <p>due to cervical neoplasia?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>Is the cervix still present?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><small>A client who has had a hysterectomy is eligible for an MCCP Pap test if the hysterectomy was due to cervical neoplasia or the cervix is present.</small></p>	<p><b>Reason for Pap test</b></p> <p><input type="checkbox"/> Routine screening</p> <p><input type="checkbox"/> Surveillance, follow-up of previous abnormal</p> <p><input type="checkbox"/> Done outside the MCCP, diagnostics only</p> <p><input type="checkbox"/> Not done, diagnostics only</p> <p><input type="checkbox"/> Breast record only</p> <p><b>Date referred to the MCCP for diagnostic workup</b></p> <p>Date referred <u>MM / DD / YYYY</u></p> <p><b>Additional procedures</b></p> <p><input type="checkbox"/> Not planned, normal follow-up</p> <p><input type="checkbox"/> Planned, further diagnostic tests needed</p> <p><b>Recommended cervical cancer screening interval for this client</b></p> <p><input type="checkbox"/> Short term follow-up, abnormal protocol <u>MM / DD / YYYY</u></p> <p><input type="checkbox"/> Every 3 years, age 21 to 65 <u>MM / DD / YYYY</u></p> <p><input type="checkbox"/> Every 5 years, with HPV, age 30 to 65 <u>MM / DD / YYYY</u></p> <p><b>Recommendations/comments</b> _____</p> <p>_____</p> <p><b>Provider's signature</b> _____</p> <p><b>Print provider's name</b> _____</p>
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### BREAST CANCER SCREEN RESULTS

<p><b>Date of Clinical Breast Exam</b> <u>MM / DD / YYYY</u></p> <p><b>Clinical Breast Exam (CBE) findings</b></p> <p><input type="checkbox"/> Normal exam</p> <p><input type="checkbox"/> Benign findings</p> <p><input type="checkbox"/> <b>Abnormal, suspicious for cancer</b></p> <p><input type="checkbox"/> CBE not done</p> <p><b>Date of Mammogram</b> <u>MM / DD / YYYY</u></p> <p><b>Mammogram type</b>    <input type="checkbox"/> Digital    <input type="checkbox"/> Conventional</p> <p><b>Mammography test results - BI-RAD Categories</b></p> <p><input type="checkbox"/> Negative - Category 1</p> <p><input type="checkbox"/> Benign - Category 2</p> <p><input type="checkbox"/> Probably benign short interval follow-up suggested - Category 3</p> <p><input type="checkbox"/> <b>Suspicious Abnormality - Category 4</b></p> <p><input type="checkbox"/> <b>Highly suggestive of malignancy - Category 5</b></p> <p><input type="checkbox"/> <b>Assessment Incomplete - Category 0</b></p> <p><b>Paid by the MCCP</b></p> <p>CBE    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Mammogram    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>Reason for Mammography test</b></p> <p><input type="checkbox"/> Routine screening</p> <p><input type="checkbox"/> Evaluate symptoms, positive CBE/prev abnormal mammogram</p> <p><input type="checkbox"/> Done outside the MCCP, diagnostics only</p> <p><input type="checkbox"/> Not done only received CBE or diagnostics</p> <p><input type="checkbox"/> Cervical record only</p> <p><b>Date referred to the MCCP for diagnostic workup</b> <u>MM / DD / YYYY</u></p> <p><b>Additional procedures</b></p> <p><input type="checkbox"/> Not planned, normal follow-up</p> <p><input type="checkbox"/> Planned, further diagnostic tests needed</p> <p><b>Recommended breast cancer screening interval for this client</b></p> <p><input type="checkbox"/> Short term follow-up, abnormal protocol <u>MM / DD / YYYY</u></p> <p>Personal history of breast cancer, or 1<sup>st</sup> degree family history, (parent, child, sibling) of pre-menopausal breast cancer</p> <p><input type="checkbox"/> Every 2 years <u>MM / DD / YYYY</u></p> <p><b>Recommendations/comments</b> _____</p> <p>_____</p> <p><b>Provider's signature</b> _____</p> <p><b>Print provider's name</b> _____</p>
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## Breast and Cervical Abnormal Form



<b>Client Name</b>	<b>Phone Number</b>	<b>State ID</b>	
<b>Social Security Number</b> - -	<b>Date of Birth</b> MM / DD / YYYY	<b>Admin Site #</b>	<input type="checkbox"/> <b>Revised</b>

Additional Procedures	Date	Results	<input type="checkbox"/> <b>Diagnostics Paid by MCSP</b>
<b>Imaging Procedures</b>		<b>Result of imaging procedure</b>	
Additional mammographic views	___/___/___	<input type="checkbox"/> Done	_____
Ultrasound	___/___/___	<input type="checkbox"/> Done	_____
Film comparison (to evaluate assessment incomplete)	___/___/___	<input type="checkbox"/> Done	_____
<b>Final imaging outcome</b> (Includes all imaging procedures and film comparisons done.)	___/___/___	<input type="checkbox"/> Negative (1) <input type="checkbox"/> Suspicious Abnormality (4) <input type="checkbox"/> Benign (2) <input type="checkbox"/> Highly suggestive of malignancy (5) <input type="checkbox"/> Probably Benign (3)	
Surgical consult, repeat breast exam	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Fine needle biopsy/cyst aspiration	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Incisional biopsy	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Excisional biopsy	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Colposcopy directed biopsy/ECC	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Diagnostic LEEP	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Diagnostic cold knife cone	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Diagnostic endocervical curettage	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Gyn consult	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer
Other - list: _____	___/___/___	<input type="checkbox"/> Normal: probably benign	<input type="checkbox"/> Abnormal: suspicious for cancer

<b>Breast Final Diagnosis</b>  <input type="checkbox"/> Cancer not diagnosed  <input type="checkbox"/> Cancer, in-situ - LCIS  <input type="checkbox"/> <b>Cancer, in-situ - DCIS</b>  <input type="checkbox"/> <b>Cancer, invasive</b>	<b>Cervical Final Diagnosis</b>  <input type="checkbox"/> Normal/benign/inflammation <input type="checkbox"/> HPV/Condylomata/Atypia <input type="checkbox"/> Mild dysplasia/CIN I (bx dx) <input type="checkbox"/> Low grade SIL (bx dx) <input type="checkbox"/> <b>Moderate dysplasia/CIN II (bx dx)</b> <input type="checkbox"/> <b>High grade SIL (bx dx)</b> <input type="checkbox"/> <b>Severe dysplasia/CIN III/Carcinoma in situ (bx dx)</b> <input type="checkbox"/> <b>Invasive cervical carcinoma (bx dx)</b> <input type="checkbox"/> Other - List: _____
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### Complete for Breast and /or Cervical Findings

<b>Status of final diagnosis/imaging: (date is required)</b> <input type="checkbox"/> Workup complete      Date ___/___/___ <input type="checkbox"/> Workup refused        Date ___/___/___ <input type="checkbox"/> Lost to follow-up      Date ___/___/___  Comments _____ _____	<b>Status of treatment: (required for bolded final diagnoses)</b> <input type="checkbox"/> Started                      Date ___/___/___ <input type="checkbox"/> Refused                     Date ___/___/___ <input type="checkbox"/> Lost to follow-up      Date ___/___/___ Next screening or follow-up due ___/___/___ <div style="text-align: right; margin-right: 50px;">Month      Year</div> Provider's signature _____  Print provider's name _____
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# Colorectal Eligibility & Enrollment Form



Last Name		First Name		Middle Initial	Other Last Names Used (If Applicable)	
Birth Date MM / DD / YYYY	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number - -		State	County
Mailing Address			City		Zip	
Annual Family Income before Taxes		Number of People in Household		Home/Cell Phone		Work Phone
Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Insurance Company		
Ethnic Background Are you Hispanic? (Spanish/ Hispanic / Latino) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			How did you hear about the program? Please check all that apply.			
Race: Check all races that apply. <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian /Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black/African American			<input type="checkbox"/> Doctor <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> NBCCEDP/Colorectal Program <input type="checkbox"/> TV <input type="checkbox"/> Mailing Flyer <input type="checkbox"/> Magazine Article <input type="checkbox"/> Radio <input type="checkbox"/> Family Member <input type="checkbox"/> Community Event <input type="checkbox"/> Other _____			

\*\*\*\*\* To Be Completed By The Client With The Assistance of The Screening Specialist \*\*\*\*\*

Do you use tobacco? No  Yes  If Yes, refer the client to the MT Quit Line. 1-800-QUIT-NOW

## Screening History / Risk Assessment

Colorectal Cancer Screening History:  
Have you ever had a colorectal cancer screening test?  Yes  No  Unknown Date: \_\_\_\_\_  
(FOBT/FIT, Colonoscopy, Sigmoidoscopy, DCBE, CTC, Stool DNA)

Personal History of Colorectal Cancer:  
Have you ever been diagnosed with colorectal cancer?  Yes  No  Unknown  
Have you ever been diagnosed with polyps?  Yes  No  Unknown  
Have you ever been diagnosed with pre-cancerous polyps or adenomatous polyps?  Yes  No  Unknown

Family History of Colorectal Cancer:  
Has a first degree relative (parent, sibling or child) been diagnosed with colorectal cancer or pre-cancerous polyps / adenomatous polyps?  Yes  No  Unknown

Are you currently experiencing any of the following symptoms?  
 Yes  No  Unknown  
Please check all that apply.  
 Rectal bleeding, dark stool, blood in the stool within the past 6 months.  
 Prolonged change in bowel habits: diarrhea/constipation for more than 2 weeks.  
 Persistent abdominal pain.  
 Symptoms of bowel obstruction, abdominal distension, nausea, vomiting.  
 Significant unintentional weight loss of 10% or more of starting body weight.

Have you been diagnosed with or are you being treated for any of the following?  Yes  No  Unknown  
Please check all that apply.  
 A genetic diagnosis of Familial Adenomatous Polyposis (FAP) or Hereditary Non Polyposis Colorectal Cancer (HNPCC)?  
 A clinical diagnosis or suspicion of FAP or HNPCC?  
 Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis)?

Did the client sign the Informed Consent Form? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Office Use Only</b>
Admin Site # _____	State ID _____
Eligibility Determined By: _____	Date Eligible _____



**Please Read and Sign**



**Client Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

## **Informed Consent and Authorization to Disclose Health Care Information**

The Montana Cancer Control Programs (MCCP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana men and women can be screened through this program for colorectal cancer and women can also receive breast and cervical cancer screenings. Each time a client is screened for colorectal cancer, they may receive either an FOBT/FIT test or a colonoscopy. If any of the initial tests for colorectal cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic colonoscopy and/or biopsy of colon tissue. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

### **Services Not Covered**

The MCCP only provides services for colorectal, breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

### **Insurance Information**

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

### **Confidentiality**

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

### **Authorization to Disclose Health Care Information**

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), the laboratory reading my FIT and/or Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask questions about the MCCP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCCP at any time.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
MM / DD / YYYY

**Print Full Name:** \_\_\_\_\_



# Colorectal Screening Form



<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Birth Date</b> MM / DD / YYYY	<b>Admin Site #</b>
<b>Social Security Number</b>	<b>Phone Number</b>	<b>State ID</b>		

<b>Date initial test scheduled or fecal kit distributed</b> Date <u>MM / DD / YYYY</u>	<b>Screening adherence</b> <input type="checkbox"/> Not done, FOBT/FIT kit not returned <input type="checkbox"/> Not done, appointment not kept.
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<b>Take Home Test :</b> <input type="checkbox"/> FOBT <input type="checkbox"/> FIT		<b>Take Home Test FOBT or FIT Section</b>	
<b>Date of result</b> <u>MM / DD / YYYY</u>	<b>Provider specialty</b>	<input type="checkbox"/> General Practitioner	<input type="checkbox"/> Internist
<b>Indication for test</b> <input type="checkbox"/> Screening	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> General Surgeon	<input type="checkbox"/> Family Practitioner
<b>Result</b>	<input type="checkbox"/> Colorectal Surgeon	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Radiologist
<input type="checkbox"/> Negative	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> OB/Gyn
<b>Outcome</b>	<b>Next test recommended in this cycle</b>		
<input type="checkbox"/> Complete	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Sigmoidoscopy	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Incomplete/Inadequate	<input type="checkbox"/> DCBE	<input type="checkbox"/> Surgery to complete diagnosis	
If Incomplete/inadequate, reason: _____	<input type="checkbox"/> None, cycle complete	<input type="checkbox"/> Other _____	

<b>Procedure Performed:</b> <input type="checkbox"/> Colonoscopy <input type="checkbox"/> DCBE		<b>Endoscopy Section I</b>	
<b>Procedure Date</b> <u>MM / DD / YYYY</u>	<b>Provider specialty</b>	<input type="checkbox"/> General Practitioner	<input type="checkbox"/> Internist
<b>Indication for test</b> <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnostic	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> General Surgeon	<input type="checkbox"/> Family Practitioner
<b>Result</b>	<input type="checkbox"/> Colorectal Surgeon	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Radiologist
<input type="checkbox"/> Normal/negative/diverticulitis/hemorrhoids	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> OB/Gyn
<input type="checkbox"/> Other findings, not suggestive of cancer/polyps	<b>Adequate bowel preparation to detect polyps greater than 5mm.</b> (decided by the endoscopist) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Polyps/suspicious for cancer/presumed cancer	<b>Was the cecum reached during this colonoscopy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Inadequate/Incomplete test with no findings	<b>If No, was the splenic flexure reached?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Pending	<b>Were there any complications?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Outcome</b> <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete/Inadequate	<b>If Yes, complete the Colorectal Endoscopy Section II Form.</b>		
<b>Was a biopsy/polypectomy performed during the endoscopy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Next test recommended in this cycle</b>		
<b>If Yes, complete the Colorectal Endoscopy Section II Form.</b>	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Sigmoidoscopy	
	<input type="checkbox"/> DCBE	<input type="checkbox"/> Surgery to complete diagnosis	
	<input type="checkbox"/> None, cycle complete	<input type="checkbox"/> Other _____	

<b>Status of Final Diagnosis</b> <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Refused diagnostic follow-up <input type="checkbox"/> Lost to follow-up before final diagnosis	<b>Final Diagnosis</b> <input type="checkbox"/> Normal/Negative <input type="checkbox"/> Hyperplastic polyps <input type="checkbox"/> Adenomatous polyp, no high grade dysplasia <input type="checkbox"/> Adenomatous polyp, with high grade dysplasia <input type="checkbox"/> Cancer	<b>Recurrent Cancers</b> <input type="checkbox"/> New colorectal cancer, primary <input type="checkbox"/> Recurrent colorectal cancer <input type="checkbox"/> Non colorectal cancer primary (metastasis from another organ) <input type="checkbox"/> Unknown
<b>Date of final diagnosis, refused, or lost to follow up</b> <u>MM / DD / YYYY</u>		

<b>Recommended screening or surveillance test for next cycle</b> <input type="checkbox"/> Take home FOBT <input type="checkbox"/> Take home FIT <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> DCBE <input type="checkbox"/> None	<b>Number of months before screening or surveillance test for next cycle.</b> (If none, leave blank) _____
	<b>Indication for screening or surveillance test for next cycle</b> <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance after a positive colonoscopy and/or surgery

**If client has a polypectomy, biopsy, surgery or complications, complete the Colorectal Endoscopy Section II Form.**

**Provider Signature** \_\_\_\_\_ **Provider Name** \_\_\_\_\_



## Colorectal Endoscopy Section II Form



<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Birth Date</b> MM / DD / YYYY	<b>Admin Site #</b>
<b>Social Security Number</b> - -	<b>Phone Number</b>	<b>State ID</b>		

<p><b>Histology of most severe polyp/lesion</b> <i>(Complete if biopsy/polypectomy was done during the colonoscopy)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Normal or other non-polyp histology</li> <li><input type="checkbox"/> Non-adenomatous polyp (inflammatory, hamartomatous, etc.)</li> <li><input type="checkbox"/> Hyperplastic polyp</li> <li><input type="checkbox"/> Adenoma, NOS (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, tubular (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, mixed tubular villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, serrated (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma with high grade dysplasia (includes in situ carcinoma)</li> <li><input type="checkbox"/> Adenocarcinoma, invasive</li> <li><input type="checkbox"/> Cancer, other</li> <li><input type="checkbox"/> Unknown/other lesions ablated, not retrieved or confirmed</li> </ul> <p><b>Number of adenomatous polyps/lesions</b> <i>(Complete if result of the histology is Adenoma or Cancer)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than 97.....Enter the number _____</li> <li><input type="checkbox"/> 97 or more adenomatous polyps/lesions</li> <li><input type="checkbox"/> At least one adenomatous polyps/lesions, exact number not known</li> <li><input type="checkbox"/> Unknown</li> </ul> <p><b>Size of largest adenomatous polyp/lesion</b> <i>(Complete if result of the histology is Adenoma or Cancer)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than 1 cm..... Enter the size _____</li> <li><input type="checkbox"/> Greater than 1 cm ...Enter the size _____</li> <li><input type="checkbox"/> Between 1 cm and 2 cm    <input type="checkbox"/> Between 2 cm and 3 cm</li> <li><input type="checkbox"/> Between 3 cm and 4 cm    <input type="checkbox"/> Between 4 cm and 5 cm</li> <li><input type="checkbox"/> Microscopic focus        <input type="checkbox"/> Diffuse</li> <li><input type="checkbox"/> Unknown (size not stated)</li> </ul>	<p><b>Histology from surgical resection</b> <i>(Complete if surgery was performed to complete diagnosis.)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Surgery recommended but not performed</li> <li><input type="checkbox"/> Normal or other non-polyp histology</li> <li><input type="checkbox"/> Non-adenomatous polyp (inflammatory, hamartomatous, etc.)</li> <li><input type="checkbox"/> Hyperplastic polyp</li> <li><input type="checkbox"/> Adenoma, NOS (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, tubular (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, mixed tubular villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, serrated (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma with high grade dysplasia (includes in situ carcinoma)</li> <li><input type="checkbox"/> Adenocarcinoma, invasive</li> <li><input type="checkbox"/> Cancer, other</li> <li><input type="checkbox"/> Unknown/other lesions ablated, not retrieved or confirmed</li> </ul> <p><b>Date surgery performed</b>    MM / DD / YYYY</p> <p><b>Complications of endoscopy requiring observation or treatment.</b> <i>(Report the worst of up to 2 serious complications of CRC testing occurring within 30 days of the test date and resulting in an ER visit or hospitalization.)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No complications</li> <li><input type="checkbox"/> Bleeding, transfusion required</li> <li><input type="checkbox"/> Bleeding not requiring transfusion</li> <li><input type="checkbox"/> Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc)</li> <li><input type="checkbox"/> Complications related to anesthesia</li> <li><input type="checkbox"/> Bowel perforation</li> <li><input type="checkbox"/> Post-polypectomy syndrome/excessive abdominal pain</li> <li><input type="checkbox"/> Death</li> <li><input type="checkbox"/> Other _____</li> </ul>
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<p><b>Print Provider's Name</b> _____</p> <p><b>Provider's Signature</b> _____</p>	<p><b>Status of treatment (Complete if final diagnosis is Cancer)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Started and/or completed</li> <li><input type="checkbox"/> Not indicated due to polypectomy</li> <li><input type="checkbox"/> Not recommended</li> <li><input type="checkbox"/> Refused</li> <li><input type="checkbox"/> Lost to follow-up</li> <li><input type="checkbox"/> Treatment pending</li> </ul> <p><b>Date of treatment</b>    MM / DD / YYYY</p>
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## PATIENT NAVIGATION SERVICE AGREEMENT PLAN

Date Initiated \_\_\_\_\_ Regional Site \_\_\_\_\_  
 Patient Navigator \_\_\_\_\_

Last Name:		First Name:		Social Security Number:	
BREAST FOLLOW-UP					
Procedure Scheduled < 60 days of abnormal finding	Provider Name	Appointment Date	Appointment Re-Scheduled	Results	Completion Date/Initial
<input type="checkbox"/> Diagnostic Mammogram					
<input type="checkbox"/> Breast Ultrasound					
<input type="checkbox"/> Surgical Consult/Repeat Breast Exam					
<input type="checkbox"/> Fine Needle Biopsy/Cyst Aspiration					
<input type="checkbox"/> Biopsy					
<input type="checkbox"/> Other (specify): _____					
CERVICAL FOLLOW-UP					
Procedure Scheduled < 60 days of abnormal finding	Provider Name	Appointment Date	Appointment Re-Scheduled	Results	Completion Date/Initial
<input type="checkbox"/> GYN Consult					
<input type="checkbox"/> Colposcopy with Directed Biopsy,ECC					
<input type="checkbox"/> Other (specify): _____					

**Monitoring Dates:**

Weekly, until date of final diagnosis or application for Medicaid treatment is made (if needed) and treatment initiated

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**Lost to follow-up/Refusal: Contact Attempts**

Contact Method	Date	Result
<input type="checkbox"/> Telephone	_____	_____
<input type="checkbox"/> Telephone	_____	_____
<input type="checkbox"/> Telephone	_____	_____
<input type="checkbox"/> Letter	_____	_____
<input type="checkbox"/> Certified Letter	_____	_____

**Montana Cancer Control Programs**  
**Acknowledgment of Refusal to Consent to Diagnostic Tests or Treatment**

**Patient Name (Print):** \_\_\_\_\_

My health care provider has recommended further diagnostic testing/treatment to me. I understand these diagnostic tests will help my health care provider diagnose cancer or the treatment recommended for cancer.

I have read and understand the paragraph(s) below that pertain to my decision to refuse diagnostic tests and/or treatment.

The health care provider named below has explained to me that I need **diagnostic test(s)** to determine if I have breast, cervical, or colorectal cancer (circle one). The test(s) that are recommended to me include:

\_\_\_\_\_

If the diagnostic test(s) have been completed, I have read and understand the result(s) and the diagnoses that are listed below:

\_\_\_\_\_

The health care provider named below has explained to me that I need **treatment** for breast, cervical or colorectal cancer (circle one). The treatment recommended to me is:

\_\_\_\_\_

My health care provider named below has explained to me that the recommended test(s)/treatment are for breast, cervical or colorectal (circle one) cancer and the likely consequences of refusing the test(s) or treatment, if I have cancer are:

\_\_\_\_\_

I understand that the refusal of the test(s)/ treatment recommended by my health care provider may endanger my health, or could lead to my death. Knowing this, I refuse to consent to such recommended test(s)/treatment.

I hereby release my doctor/health care provider, \_\_\_\_\_(Print Name)  
and the Montana Department of Health and Human Services (DPHHS) from any liability or responsibility for not providing the test(s)/treatment described and referred to above.

\_\_\_\_\_(Date)  
Patient signature

\_\_\_\_\_(Date)