
 MONTANA CANCER CONTROL PROGRAMS		<b>MCCP Breast and Cervical Cancer Screening Form</b>			
Client Name _____		Phone Number _____	Social Security Number _____		Date of Birth _____

<p><b><u>Risk Assessment for Cervical Cancer</u></b></p> <p><input type="checkbox"/> Patient is at high risk</p> <p><input type="checkbox"/> Not at high risk</p> <p><input type="checkbox"/> Provider did not assess</p> <p><b>Date of Pap test</b> _____/_____/_____</p> <p><b>Result of Pap test</b></p> <p><input type="checkbox"/> Negative for intraepithelial lesion/malignancy</p> <p><input type="checkbox"/> Unsatisfactory</p> <p><input type="checkbox"/> Low Grade SIL (including HPV change)</p> <p><input type="checkbox"/> Atypical squamous cells (ASC-US)</p> <p><input type="checkbox"/> Atypical squamous cells (ASC-H)</p> <p><input type="checkbox"/> High Grade SIL/HPV</p> <p><input type="checkbox"/> Squamous Cell Carcinoma</p> <p><input type="checkbox"/> Atypical Glandular cells</p> <p><input type="checkbox"/> Adenocarcinoma in situ (AIS)</p> <p><input type="checkbox"/> Adenocarcinoma</p> <p><b>Reason for Pap test</b></p> <p><input type="checkbox"/> Routine Pap test</p> <p><input type="checkbox"/> Patient under surveillance (previous abnormal)</p> <p><input type="checkbox"/> Pap after a primary HPV +</p> <p><input type="checkbox"/> Pap test not done</p>	<p><b>Respond for ALL clients screened for Cervical Cancer</b></p> <p>Has this client had a hysterectomy?    <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If “Yes” was the hysterectomy due to cervical neoplasia?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Is the cervix still present?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p><b>Date of HPV test</b> _____/_____/_____</p> <p><b>Result of HPV test</b></p> <p><input type="checkbox"/> Positive with positive genotyping (types 16 or 18)</p> <p><input type="checkbox"/> Positive with negative genotyping (positive HPV but not types 16 or 18)</p> <p><input type="checkbox"/> Positive with genotyping not done/unknown genotyping</p> <p><input type="checkbox"/> Negative</p> <p><b>Reason for HPV test</b></p> <p><input type="checkbox"/> Co-Testing/Screening</p> <p><input type="checkbox"/> Reflex</p> <p><input type="checkbox"/> HPV test not done</p> <p><b>Additional Procedures</b></p> <p><input type="checkbox"/> Not planned, normal follow-up   <input type="checkbox"/> Planned, further diag. 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    _____/_____/_____</p> <p><input type="checkbox"/> 3 years, Pap alone, age 21 to 65    _____/_____/_____</p> <p><input type="checkbox"/> 5 years, Pap with HPV, age 30 to 65    _____/_____/_____</p> <p><input type="checkbox"/> 5 years, HPV alone, age 30 to 65    _____/_____/_____</p>
--	--

<p><b><u>Risk Assessment for Breast Cancer</u></b></p> <p><input type="checkbox"/> Patient is at high risk</p> <p><input type="checkbox"/> Not at high risk</p> <p><input type="checkbox"/> Provider did not assess</p> <p><b>Date of Mammogram</b> _____/_____/_____</p> <p><b>Result of Mammogram</b></p> <p><input type="checkbox"/> Negative (BI-RADS 1)</p> <p><input type="checkbox"/> Benign findings (BI-RADS 2)</p> <p><input type="checkbox"/> Probably benign (BI-RADS 3)</p> <p><input type="checkbox"/> Suspicious abnormality (BI-RADS 4)</p> <p><input type="checkbox"/> Highly suggestive of malignancy (BI-RADS 5)</p> <p><input type="checkbox"/> Film comparison needed (BI-RADS 0)</p> <p><input type="checkbox"/> Assessment incomplete</p> <p><input type="checkbox"/> Known Biopsy-Proven malignancy</p> <p><input type="checkbox"/> Unsatisfactory</p> <p><b>Reason for Mammogram</b></p> <p><input type="checkbox"/> Routine screening</p> <p><input type="checkbox"/> Symptoms, abnormal CBE or previous abnormal mammogram</p> <p><input type="checkbox"/> Mammogram not done</p>	<p><b>Date of CBE</b> _____/_____/_____</p> <p><b>Result of CBE</b></p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> Benign</p> <p><input type="checkbox"/> Discrete Palp Mass (Suspicious for cancer)</p> <p><input type="checkbox"/> Discrete Palp Mass (Dx Benign)</p> <p><input type="checkbox"/> Focal pain or tenderness</p> <p><input type="checkbox"/> CBE not done</p>	<p><b>Date of MRI</b> _____/_____/_____</p> <p><b>Result of MRI</b></p> <p><input type="checkbox"/> Negative</p> <p><input type="checkbox"/> Benign findings</p> <p><input type="checkbox"/> Probably benign</p> <p><input type="checkbox"/> Suspicious</p> <p><input type="checkbox"/> Highly Suggestive of malignancy</p> <p><input type="checkbox"/> Incomplete (needs add. imaging)</p> <p><input type="checkbox"/> Known Biopsy-Proven malignancy</p> <p><b>Reason for MRI</b></p> <p><input type="checkbox"/> Screening   <input type="checkbox"/> Diagnostic</p> <p><input type="checkbox"/> MRI not done</p>
<p><b>Additional Procedures</b></p> <p><input type="checkbox"/> Not planned, normal follow-up   <input type="checkbox"/> Planned, further diag. 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    _____/_____/_____</p> <p><input type="checkbox"/> 1-year follow-up ____/____/____   <input type="checkbox"/> 2-year routine screening ____/____/____</p> <p><b>Recommendations/comments:</b> _____</p> <p>_____</p> <p><b>Provider's Signature</b> _____</p> <p><b>Print provider's name</b> _____</p>		