

## Instructions for Cervical Diagnostic Form (back of diagnostic form)

### *Purpose*

To document the notification, follow-up, and treatment dates of patients with an abnormal Pap test, HPV test and/or pelvic exam result.

### *Used by*

Community Health Centers (CHCs) and Area Health Education Centers (AHECs)

### *Explanations and definitions*

Field	Directions
BreastCare #7777	Enter BreastCare number from the patient's BreastCare card that begins with four sevens.
Diagnostic Referral	Check Yes if patient is referred to the LHU for diagnostic evaluation following an abnormal Pap before enrolling into BreastCare
Date to Central Office	Enter date(s) this form is faxed to Central Office.
Name of Patient	Self-explanatory.
Birth Date	Self-explanatory.
Social Security Number	Self-explanatory. Enter N/A if patient has no SSN.
Name of Clinic	Enter name of clinic, not individual's name
Clinic Phone Number	Enter clinic's phone number, including area code.
Contact Nurse	BreastCare Case Manager/designee who completes this form.
INITIATE FORM FOR THESE ABNORMAL RESULTS AND REFER TO CARE COORDINATOR	Check appropriate box/boxes for abnormal results. Cervical polyps are not considered suspicious for cancer. Abnormal cervix is checked only in the presence of a fungating mass, suspicious for cancer. <b>NOTE: This form is completed only for results that require colposcopy or MD consult.</b>
Diagnostic Procedures and/or Consultations	Check the appropriate box and enter appointment date, location, and date done. Check results for procedures that are done. If patient misses the first appointment, circle date, reschedule appointment, and enter date in second space.
Treatment Indicated through Treatment Not Indicated	Check appropriate box. If treatment is indicated, enter appointment date and location. If patient misses first appointment, circle date, reschedule appointment, and enter date in second space. Check appropriate box(s) for all additional types of

Field	Directions
	<p>treatment the patient receives. Check only treatment modalities listed and enter date treatment is started.</p> <p><b>This box is completed by Regional Care Coordinator if client is referred per case management policy.</b></p>
FINAL DIAGNOSIS	<p>Check appropriate box and enter date of final diagnosis. After the final tissue specimen has been submitted (i.e., cervical biopsy, LEEP, hysterectomy), <b>the final diagnosis is determined by the tissue pathology with the highest grade.</b></p>
COMPLETE ONLY IF CANCER IS DIAGNOSED	<p>Check appropriate box for staging information obtained from biopsy/surgeon/pathology report.</p> <p><b>*This box is completed by Regional Care Coordinator if client referred per case management policy.</b></p>
Follow-Up Recommendation	<p>Check appropriate box. If date of next recommended Pap test or MD visit is less than one year, enter number of months, when appointment is scheduled, and date. If patient misses first appointment, circle date, reschedule appointment, and enter date in second space.</p>
Date Of Closure/Reason For Closing	<p>Check appropriate box and enter date. If patient is lost to follow-up or refuses, check appropriate box indicating reason. If Other is checked, specify, e.g., husband forbids, no access to provider, no transportation, religion.</p> <p><b>NOTE:</b> Check Declines ADH Services box only if the patient is not returning to ADH for follow-up/annual Pap smears.</p>

***Mechanics and filing***

Initiate and place loosely in the patient's record a Cervical Diagnostic Form each time there is an abnormal Pap test, HPV test and/or pelvic exam. Use the Cervical Diagnostic Form to track a patient until follow-up is complete.

When a colposcopy or MD Consult appointment is made and when follow-up is completed, fax an updated copy to BreastCare Data Manager at 501-661-2264

**\*Refer to Regional Care Coordinator for all Pap, HPV or pelvic results requiring colposcopy.**

BreastCare # 7777 _____	<b>ARKANSAS DEPARTMENT OF HEALTH</b>	Date to Central Office
<b>Diagnostic Referral</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	BreastCare – Slot 11 Cervical Diagnostic Form FAX TO: 501-661-2264	Date to Central Office

Name of Patient    Last	First	MI	Birth Date	Social Security Number
Name of Clinic		Clinic Phone Number		Contact Nurse

<input type="checkbox"/> Abnormal Cervix (Suspicious for Cancer) Date _____	Date of Abnormal Pap Test: _____  <input type="checkbox"/> LGSIL <input type="checkbox"/> AGC/AIS <input type="checkbox"/> HGSIL/CIS <input type="checkbox"/> ASC-H <input type="checkbox"/> Carcinoma <input type="checkbox"/> Other _____	Date of Positive High Risk HPV Test: _____
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Diagnostic Procedures And/Or Consultations			
Appt. date	<input type="checkbox"/> MD Consult		
1) _____	Date Done _____		<input type="checkbox"/> Negative/WNL
2) _____	Location _____		<input type="checkbox"/> Inflammation/Infection/HPV
			<input type="checkbox"/> Other Abnormality
			<input type="checkbox"/> Unsatisfactory
Appt. date	<input type="checkbox"/> Colposcopy Without Biopsy		
1) _____	Date Done _____		<input type="checkbox"/> WNL
2) _____	Location _____		<input type="checkbox"/> Inflammation/Infection/HPV
			<input type="checkbox"/> Other Abnormality
			<input type="checkbox"/> Unsatisfactory
			<input type="checkbox"/> Not Done, Other Unknown Reason
Appt. date	<input type="checkbox"/> Colposcopy With Cervical Biopsy		
1) _____	Date Done _____		Biopsy Result:
2) _____	Location _____		<input type="checkbox"/> WNL
			<input type="checkbox"/> HPV/Condylomata/Atypia
			<input type="checkbox"/> CIN-1/ Mild Dysplasia
			<input type="checkbox"/> CIN-2/Moderate Dysplasia
			<input type="checkbox"/> CIN-3/Severe Dysplasia/CIS/AIS
			<input type="checkbox"/> Invasive Carcinoma
			<input type="checkbox"/> Adenocarcinoma
Appt. date	<input type="checkbox"/> ECC with colposcopy		
1) _____	<input type="checkbox"/> ECC without colposcopy		Curettage Result:
2) _____	Date Done _____		<input type="checkbox"/> WNL
	Location _____		<input type="checkbox"/> HPV/Condylomata/Atypia
			<input type="checkbox"/> CIN-1/Mild Dysplasia
			<input type="checkbox"/> CIN-2/Moderate Dysplasia
			<input type="checkbox"/> CIN-3/Severe Dysplasia/CIS/AIS
			<input type="checkbox"/> Invasive Carcinoma
			<input type="checkbox"/> Adenocarcinoma
Appt. date	<input type="checkbox"/> Endometrial Biopsy		
1) _____	Date Done _____		Biopsy Result:
2) _____	Location _____		<input type="checkbox"/> WNL
			<input type="checkbox"/> HPV/Condylomata/Atypia
			<input type="checkbox"/> CIN-1/Mild Dysplasia
			<input type="checkbox"/> CIN-2/Moderate Dysplasia
			<input type="checkbox"/> CIN-3/Severe Dysplasia/CIS/AIS
			<input type="checkbox"/> Invasive Carcinoma
			<input type="checkbox"/> Adenocarcinoma
Appt. date	<input type="checkbox"/> LEEP Date _____		
1) _____	<input type="checkbox"/> Conization Date _____		Biopsy Result
2) _____	Location _____		<input type="checkbox"/> WNL
			<input type="checkbox"/> HPV/Condylomata/Atypia
			<input type="checkbox"/> CIN-1/ Mild Dysplasia
			<input type="checkbox"/> CIN-2/Moderate Dysplasia
			<input type="checkbox"/> CIN-3/Severe Dysplasia/CIS/AIS
			<input type="checkbox"/> Invasive Carcinoma
			<input type="checkbox"/> Adenocarcinoma

<input type="checkbox"/> Treatment Indicated <input type="checkbox"/> Treatment Not Indicated Appt. date 1) _____ 2) _____ Location _____ enter date(s) for treatment(s) <input type="checkbox"/> Cryotherapy _____ <input type="checkbox"/> Laser _____ <input type="checkbox"/> LEEP/LETZ _____ <input type="checkbox"/> Conization _____ <input type="checkbox"/> Hysterectomy _____ <input type="checkbox"/> Radiation _____ <input type="checkbox"/> Chemotherapy _____	<b>FINAL DIAGNOSIS</b> Date _____  <input type="checkbox"/> WNL <input type="checkbox"/> HPV/Condylomata/Atypia <input type="checkbox"/> CIN-1/Mild Dysplasia <input type="checkbox"/> CIN-2/Moderate Dysplasia <input type="checkbox"/> CIN-3/Severe Dysplasia/CIS/AIS <input type="checkbox"/> Invasive Carcinoma <input type="checkbox"/> Adenocarcinoma	<b>COMPLETE ONLY IF CANCER IS DIAGNOSED</b> Stage At Diagnosis <input type="checkbox"/> Stage I AJCC <input type="checkbox"/> Stage II AJCC <input type="checkbox"/> Stage III AJCC <input type="checkbox"/> Stage IV AJCC
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**FOLLOW-UP RECOMMENDATION:**    Next Pap 1 yr    Next Pap in \_\_\_\_\_ months   Next MD visit \_\_\_\_\_ months

<b>DATE OF CLOSURE:</b> _____ <input type="checkbox"/> Follow-Up Complete	<b>Send to CO</b> Patient Refused (check one and refer to CC) <input type="checkbox"/> no symptoms/low risk <input type="checkbox"/> too busy <input type="checkbox"/> illness/injury <input type="checkbox"/> fear <input type="checkbox"/> other _____	<b>REASON FOR CLOSING:</b> Lost to Follow-up (check one and refer to CC) <input type="checkbox"/> Moved <input type="checkbox"/> DNKA <input type="checkbox"/> Unable to Locate <input type="checkbox"/> Deceased <input type="checkbox"/> Declines ADH Services
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