West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH | Office of Maternal, Child and Family Health

West Virginia Breast and Cervical Cancer Screening Program
Patient Data Form

West Virginia Breast & Cervical Cancer Screening Program
You're Worth It

WVBCCSP Screening Facility:_____

WVBCCSP #: _____ **Visit Date**: _____ /_____ /_____

Patient Name (Last, First, MI): _____

Social Security #: _____-_____- _____ **Date of Birth**: _____ /_____ /_____

Visit Type (check all that apply)

☐ Initial ☐ Referral for Previous Enrollement ☐ Referral for Enrollment
☐ Breast ☐ Repeat Pap/Clinical Breast Exam
☐ Cervical ☐ Referral for Medicaid Treatment Act

Clinician Time

Clinician Time: _____ Minutes (ONLY report time spent with patient)

Patient Breast and Cervical Service Data

Prior Pap test: ☐ Yes ☐ No ☐ Unknown Date:____/____/_____ (estimated or partial dates accepted)

Does patient have a cervix?	☐ Yes	☐ No
Has patient had a hysterectomy?	☐ Yes	☐ No
Was hysterectomy due to cervical cancer?	☐ Yes	☐ No
High risk for cervical cancer:	☐ Yes	☐ No
	☐ Not assessed	☐ Unknown

Prior Mammogram?
☐ Yes ☐ No Date: ___/___/___
Previous History of Breast Cancer?
☐ Yes ☐ No
High risk for breast cancer?
☐ Yes ☐ No
☐ Not assessed ☐ Unknown

Tobacco Use

☐ Never Used
☐ Former User
☐ Current User
Referred to Tobacco Quitline?
☐ Yes ☐ No ☐ Refused
Referred to other tobacco cessation service?
☐ Yes ☐ No ☐ Refused

PELVIC EXAM PERFORMED Yes ☐ No ☐

☐ Normal ☐ Abnormal Date Performed: _____/_____/_____

Pap Test Yes ☐ No ☐

Date Performed: _____/_____/_____ Next Eligible Pap Test Date: _____/_____/_____

Pap Test Results

Results: _____

☐ Result Pending

Indication for Pap Test

☐ Screening (routine Pap Test)
☐ Surveillance for positive, abnormal test
☐ Non-program Pap, referred in for dx evaluation
☐ Pap after primary HPV+
☐ Unknown

HPV Test ☐ Yes ☐ No

Date Performed: _____/_____/_____

☐ Clinician Collected HPV ☐ Self-Collected HPV

HPV Test Result: Check ONLY one (1) result:

☐ Positive (genotyping done, types 16 or 18)
☐ Positive (genotyping done, NOT types 16 or 18)
☐ Positive (genotyping NOT done)
☐ Negative

Indication for HPV test:

☐ Co-test or Screening ☐ Test not done
☐ Reflex ☐ Unknown

Cervical service paid for by WVBCCSP

☐ Yes ☐ No

Diagnostic workup Planned for Cervical?

☐ Yes ☐ No

CLINICAL BREAST EXAM (Optional for asymptomatic patients) ☐ Yes ☐ No

Clinical Breast Exam (CBE) Results:

☐ Normal/Benign findings
☐ Bloody/serous nipple discharge*
☐ Discrete palpable mass*
☐ Focal pain or tenderness*
☐ Nipple/areolar scaliness*
☐ Skin dimpling/retraction*

Breast Services Paid for by WVBCCSP?

☐ Yes ☐ No

Diagnostic workup Planned for Breast?

☐ Yes ☐ No

Comments for Breast and Cervical Services

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Exam performed by: _____

Staff Signature:_____ Date: _____/_____/_____

*** Indicates Diagnostic Work-up Required**