

**WV Breast and Cervical Cancer Screening Program
 Patient Navigation Form**

WVBCCSP Screening Facility: _____
 WVBCCSP #: _____ Initial Contact Date (mm/dd/yyyy): ____/____/____

Social Security #: _____ Date of Birth (mm/dd/yyyy): ____/____/____
 Client Name (Last, First, MI): _____

Reason for Navigation (check only one for which Patient Navigation was initiated)

<input type="checkbox"/> Breast and Cervical Cancer Screening	<input type="checkbox"/> Breast Diagnostic Services	<input type="checkbox"/> Cervical Cancer Treatment
<input type="checkbox"/> Breast Cancer Screening Only	<input type="checkbox"/> Cervical Diagnostic Service	<input type="checkbox"/> Medicaid Treatment Act Referral
<input type="checkbox"/> Cervical Cancer Screening Only	<input type="checkbox"/> Breast Cancer Treatment	<input type="checkbox"/> WISEWOMAN Services (for WISEWOMAN providers only)

Medical Insurance	Resources/Referrals Provided
<input type="checkbox"/> Insured: Medicaid <input type="checkbox"/> Insured: Medicare <input type="checkbox"/> Insured: Private <input type="checkbox"/> Uninsured: WVBCCSP <input type="checkbox"/> Uninsured: Self Pay	<input type="checkbox"/> Transportation Assistance/Referral <input type="checkbox"/> Translator/Language Services <input type="checkbox"/> Provided Education <input type="checkbox"/> Financial Assistance Referral <input type="checkbox"/> Social Work Referral <input type="checkbox"/> Community Resources Referral <input type="checkbox"/> Flexible Appointment Time <input type="checkbox"/> Child/Elder Care Resource Referral <input type="checkbox"/> Pregnancy Resource Referral <input type="checkbox"/> Referral to Female Healthcare Provider <input type="checkbox"/> Referral to County WVDHS Office <input type="checkbox"/> Other: _____

Barriers	Resolved?																																		
<input type="checkbox"/> Language: Interpreter needed <input type="checkbox"/> Cultural beliefs/Myths about cancer <input type="checkbox"/> Financial issues <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Caring for child or elder (Needing flexible time appointment) <input type="checkbox"/> Fear of test/cancer/CVD <input type="checkbox"/> Gender of provider (Prefer same gender care provider) <input type="checkbox"/> Work (difficulty requesting time off to receive medical care) <input type="checkbox"/> Disability (Needing accommodation for appointment) <input type="checkbox"/> Insurance Issues (only when it is a barrier for completing diagnostic services and or treatment) <input type="checkbox"/> Knowledge Deficit <input type="checkbox"/> Family problems, explain: _____ <input type="checkbox"/> Other: _____	<table border="0"> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> </table>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No																																		

Documentation of Contacts (At least 2 contacts are required)

Date of Contact	Type of Contact	Contact Notes
____/____/____	<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Mail	
____/____/____	<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Mail	

Patient Navigation Outcomes

<input type="checkbox"/> Completed services needed this time <input type="checkbox"/> Refused treatment <input type="checkbox"/> Lost to Follow-up *Please feel free to provide additional outcome comments in the notes section.	Make several attempts before checking these	Notes: _____ _____ _____
--	--	-----------------------------------

Navigator Signature: _____ Date (mm/dd/yyyy): ____/____/____