WV Breast and Cervical Cancer Screening Program
Patient Data Form

WVBCCSP Screening Facility:_____

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

Patient Name (Last, First, MI): _____

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

VISIT TYPE

☐ Initial ☐ Annual Cervical ☐ Ref. for Prev. Enroll
☐ Annual Routine ☐ Repeat Pap/CBE ☐ Ref. for MTA
☐ Annual Breast ☐ Ref. for Enrollment

CERVICAL SERVICES DATA

Prior Pap test? ☐ Yes, Date: _____ /_____ /_____ ☐ No
(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

PELVIC EXAM PERFORMED ☐ Yes ☐ No

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

PAP TEST

Date Performed: _____ /_____ /_____

Check ONLY one (1) result:

Next Eligible Pap Test date:_____/_____/_____

☐ Adenocarcinoma*
☐ Adenocarcinoma In Situ (AIS)*
☐ Atypical glandular cells (AGC)*
☐ Atypical squamous cells, cannot exclude HSIL (ASC-H)*
☐ Atypical squamous cells of undetermined significance (ASC-US)
☐ High-grade SIL (HSIL)*
☐ Low-grade SIL (LSIL)/including HPV changes
☐ Negative for intraepithelial lesion or malignancy
☐ Other-specify: _____
☐ Result Pending
☐ Result unknown, presumed abnormal, non-program*
☐ Squamous cell carcinoma*
☐ Unsatisfactory

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+
☐ No Pap
☐ No cervical services , Breast record only
☐ Unknown

HPV

Date Performed: _____ /_____ /_____

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
☐ Reflex
☐ Test not done
☐ Unknown

CERVICAL SERVICES PAYMENT

Cervical Services Paid for by WVBCCSP? ☐ Yes ☐ No

CLINICIAN TIME

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

SMOKING STATUS/TOBACCO REFERRALS

Smoking History? ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked
Referred to a tobacco QuitLine: ☐ Yes ☐ No ☐ Refused
Referred to other tobacco cessation service: ☐ Yes ☐ No ☐ Refused

BREAST SERVICES DATA

Prior Mammogram? ☐ Yes ☐ No Date: _____ /_____ /_____

Previous History of Breast Cancer? ☐ Yes ☐ No

HIGH RISK FOR BREAST CANCER?

☐ Yes ☐ No ☐ Not Assessed ☐ Unknown

CLINICAL BREAST EXAM

Date Performed:_____/_____/_____

Check Only one (1) result

☐ Normal/Benign findings-scheduled CBE in one year

☐ Abnormality/Suspicious for Cancer- Diagnostic Evaluation Needed*

Select all that applies
☐ Bloody/serous nipple discharge
☐ Discrete palpable mass
☐ Focal pain or tenderness
☐ Skin dimpling /retraction
☐ Nipple/areolar scaliness

☐ Not done normal CBE for past 12 months
☐ Not done other/unknown reason
☐ Refused

BREAST SERVICES PAYMENT

Breast Services Paid for by WVBCCSP? ☐ Yes ☐ No

GENERAL COMMENTS—Breast and Cervical Services
Diagnostic workup Planned?

Breast	Cervical
☐ Yes ☐ No	☐ Yes ☐ No

Comments:

REQUIRED SIGNATURES

Exam performed by:

Clinician's Signature

Date: _____ /_____ /_____

*** Indicates Diagnostic Work-up Required**

Original: WVBCCSP Two (2) copies: Provider OMCFH/WVBCCSP Form #Y106 Rev. 06/23

Send to: WVBCCSP 350 Capitol Street, Room 427, Charleston, WV 25301-3714