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**)**

□ Breast and Cervical Cancer Screening
□ Breast Cancer Screening Only
□ Cervical Cancer Screening Only
□ Breast Diagnostic Services
□ Cervical Diagnostic Service
□ WISEWOMAN Services (for WISEWOMAN providers only)
□ Breast Cancer Treatment
□ Cervical Cancer Treatment
□ MTA Ref.

Medical Insurance

□ Insured: Medicaid
□ Insured: Medicare
□ Insured: Private
□ Uninsured: WVBCCSP
□ Uninsured: Self Pay

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

Resources/Referrals Provided

□ Transportation Assistance/Referral
□ Translator/Language Services
□ Provided Education
□ Financial Assistance Referral
□ Social Work Referral
□ Community Resources Referral
□ Flexible Appointment Time
□ Child/Elder Care Resource Referral
□ Pregnancy Resource Referral
□ Referral to Female Healthcare Provider
□ Referral to County WVDHHR Office
□ Other: _____

Documentation of Contacts

Date of Contact	Type of Contact	Result of Each Contact	Contact Notes
	□ Face-to-Face □ Phone □ Mail	□ Spoke with Client □ Did Not Speak with Client	
	□ Face-to-Face □ Phone □ Mail	□ Spoke with Client □ Did Not Speak with Client	

Patient Navigation Outcomes

□ Completed services needed this time

□ Refused treatment
□ Lost to Follow-up

Make several attempts before checking these boxes.

*Please feel free to provide additional outcome comments in the notes section.

Notes:

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

Original: WVBCCSP Two (2) copies: Provider OMCFH/WVBCCSP Form #Y104 Rev. 06/23

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