Cervical Follow-up & Tracking Form

Last Name:	First Name:	MI:	Maiden Name:
Clinic	☐ New Screen ☐ Follow-Up ☐ Rescreen		Enrollment #:

FAMILY HISTORY *(Required)*

1. Client at high risk for cervical cancer?
   - ☐ Yes (e.g. client was exposed to diethylstilbestrol (DES) or is considered immunocompromised)
   - ☐ No
   - ☐ Not assessed

PAP TEST, PELVIC EXAM AND HPV TEST *(Required)*

2. Prior Pap test: ☐ Yes ☐ No ☐ Unknown   Prior Pap test date: ______________ (*MM/DD/YYYY*)
3. Indication for today's Pap test:
   - ☐ Routine Pap test
   - ☐ Client under surveillance for a previous abnormal test. Also considered a "rescreened" client
   - ☐ Pap test done by a non-program funded provider, client referred in for diagnostic evaluation
     Date of referral: ______________ (*MM/DD/YYYY*)
   - ☐ Pap test done after primary HPV test positive
   - ☐ Pap test not done

Why was Pap test not done? ☐ Refused ☐ Not Needed ☐ Needed but not performed

(if no Pap test done, skip questions 5-9)

4. Pelvic exam date: ______________(*MM/DD/YYYY*)
5. Today's Pap test date: ______________(*MM/DD/YYYY*)
   - ☐ 3 year (without HPV test)
   - ☐ 5 year (with HPV test)
6. What were today's Pap test results?
   - ☐ Negative (for intraepithelial lesion or malignancy)
   - ☐ Infection/Inflammation/Reactive Changes
   - ☐ Atypical Squamous Cells of Undetermined Significance (ASC-US)*
   - ☐ Low-Grade Squamous Intraepithelial Lesion (LSIL)*
   - ☐ Atypical Squamous Cells cannot exclude HSIL (ASC-H Beth2001)*
   - ☐ High-Grade Squamous Intraepithelial Lesion (HSIL)*
   - ☐ Squamous Cell Carcinoma*
   - ☐ Abnormal Glandular Cells (AGC)*
   - ☐ Adenocarcinoma in situ (AIS)
   - ☐ Adenocarcinoma
   - ☐ Result Pending
   - ☐ Results unknown, presumed abnormal, from non-program funded sources
   - ☐ Other Pap results:

***May require further diagnostic evaluation.**

7. Cervix present?
   ☐ Yes (Cervical) ☐ No (Vaginal)
8. Specimen type:
   ☐ Conventional ☐ Liquid-based ☐ Other
9. Specimen adequacy?
   - ☐ Satisfactory
   - ☐ Unsatisfactory-Repeat Pap Required
10. Indication for HPV test:
    - ☐ Co-Test or Screening ☐ Reflex
    - ☐ Not Done ☐ Unknown
11. HPV Test Result:
    - ☐ Positive with genotyping not done
    - ☐ Negative
    - ☐ Positive with positive genotyping (types 16 or 18)
    - ☐ Positive with negative genotyping (positive HPV, but not types 16 or 18)
    - ☐ Not Done
12. HPV test date: __________(*MM/DD/YYYY*)
13. Where was Pap test/Pelvic exam performed?
    Facility/Clinic:
14. Was client referred for immediate cervical diagnostic workup to reach final diagnosis?
    ☐ Yes ☐ No

	*May require further diagnostic evaluation.

DIAGNOSTIC PROCEDURES *(if applicable)*

15. Colposcopy without Biopsy: ☐ Yes ☐ No Procedure Date: ________________(*MM/DD/YYYY*) Procedure Site: ________________________ Results: ☐ Negative (WNL) ☐ Inflammatory Reaction Changes ☐ Other abnormality ☐ Unsatisfactory ☐ Refused	16. Colposcopy-directed Biopsy/Endocervical Curettage (ECC): ☐ Yes ☐ No Procedure Date: ________________(*MM/DD/YYYY*) Procedure Site: ________________________ Results: ☐ Adenocarcinoma ☐ Cervical Intraepithelial Neoplasia (CIN) I ☐ CIN II ☐ CIN III/Carcinoma in situ (CIS) ☐ Invasive Carcinoma ☐ Negative (WNL) ☐ Other non-cancerous abnormality ☐ Refused
17. Other Procedure #1: ☐ Yes ☐ No Procedure Date: ________________(*MM/DD/YYYY*) ☐ ECC ☐ LEEP ☐ Cone ☐ Other: Procedure Site: ________________________ Results: ☐ Adenocarcinoma ☐ CIN I ☐ CIN II ☐ CIN III/ CIS ☐ Invasive Carcinoma ☐ Negative (WNL) ☐ Other non-cancerous abnormality ☐ No tissue present (ECC only) ☐ Refused	18. Other Procedure #2: ☐ Yes ☐ No Procedure Date: ________________(*MM/DD/YYYY*) ☐ ECC ☐ LEEP ☐ Cone ☐ Other: Procedure Site: ________________________ Results: ☐ Adenocarcinoma ☐ CIN I ☐ CIN II ☐ CIN III/ CIS ☐ Invasive Carcinoma ☐ Negative (WNL) ☐ Other non-cancerous abnormality ☐ No tissue present (ECC only) ☐ Refused
WORK-UP STATUS (Required)	**TREATMENT STATUS (Required)**
19. Status of the final diagnosis? ☐ Work-up complete ☐ Irreconcilable (conflicting test results) ☐ Deceased ☐ Client lost to follow-up ☐ Workup refused	20. Status of cervical cancer treatment? ☐ Treatment started ☐ Client lost to follow-up ☐ Treatment refused ☐ Treatment not recommended ☐ May require additional information
21. Date of final diagnosis: ___________ (*MM/DD/YYYY*)	22. Date of treatment status: ___________ (*MM/DD/YYYY*)
23. Final Diagnosis: ☐ Normal/Benign Reaction/Inflammation ☐ HPV/Condylomata/Atypia ☐ CIN I/ Mild Dysplasia (biopsy diagnosis) ☐ CIN II/ Moderate Dysplasia (biopsy diagnosis)§ ☐ CIN III/ Severe Dysplasia/ Carcinoma in situ (Stage 0)§(biopsy diagnosis) ☐ Invasive Cervical Carcinoma (biopsy diagnosis)§ ☐ Other: ☐ Low grade SIL (biopsy diagnosis)§	24. Client enrolled in Medicaid for treatment? ☐ Yes ☐ No If no, why not?:

☐ High grade SIL (biopsy diagnosis)§

§ Requires Treatment

CASE SUMMARY *(if applicable)*

25. Stage Information:	If AJCC stage not available:	26. Procedures and treatment (Check all that apply)
AJCC stage ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV	**Summary stage** ☐ Local ☐ Regional ☐ Distant	Procedure Date: ________________(*MM/DD/YYYY*) ☐ Hysterectomy ☐ Radiation ☐ Chemotherapy ☐ Loop Electroexcision (LEEP) ☐ Conization ☐ Other:

Comments: ____

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TRANSFER OF CARE *(if applicable)*

27. Name of new provider:

29. Address of new provider:

28. Phone of new provider:

30. Reason for transfer:

Form Completed ___________________ (*MM/DD/YYYY*) **Form Completed by:**

AICAF Use Only

31. Which services were paid by AICAF?

☐ Pelvic exam
☐ Pap test
☐ HPV test
☐ Colposcopy without biopsy
☐ Colposcopy-directed biopsy/ECC
☐ LEEP
☐ Cone
☐ Other: