



Cervical Screening and Diagnostic Form
Every Woman's Life - Virginia Department of Health

Last Name	First Name	MI	Maiden Name
Admin Site	<input type="checkbox"/> New Screen <input type="checkbox"/> Follow-up <input type="checkbox"/> Rescreen		SSN (or alien ID)

PAP TEST AND PELVIC EXAM

1. Indication for Pap test: <input type="checkbox"/> Routine Pap test <input type="checkbox"/> Client under surveillance for a previous abnormal test <input type="checkbox"/> Pap test done by a non-program funded provider, client referred in for diagnostic evaluation Date client was referred into program for cervical diagnostic workup: ____/____/____ <input type="checkbox"/> Pap test not done. Client proceeded directly for diagnostic work-up or HPV test. <input type="checkbox"/> Unknown	
2. Pelvic exam date: ____ / ____ / ____ (mm/dd/yyyy) 3. Pap test date: ____ / ____ / ____ (mm/dd/yyyy) 4. What were the Pap test results? <input type="checkbox"/> Negative (for intraepithelial lesion or malignancy) <input type="checkbox"/> ASC-US <input type="checkbox"/> LGSIL <input type="checkbox"/> ASC-H <input type="checkbox"/> HGSIL <input type="checkbox"/> Squamous cell carcinoma <input type="checkbox"/> Abnormal Glandular Cells (AGC) <input type="checkbox"/> Other result: _____ <input type="checkbox"/> Result unknown, presumed abnormal, from non-program funded source	5. Cervix present? <input type="checkbox"/> Yes (Cervical) <input type="checkbox"/> No (Vaginal) 6. Specimen Type: <input type="checkbox"/> Conventional <input type="checkbox"/> Liquid-based <input type="checkbox"/> Other 7. Specimen adequacy? <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory - Repeat Pap 8. Was the Pap test paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. HPV Test Result? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done HPV test date: ____ / ____ / ____ (mm/dd/yyyy) 10. Was the HPV test paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Where was the Pap test/Pelvic exam performed? Facility/Clinic: _____ 12. Was the client referred for immediate cervical diagnostic workup? <input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSTIC PROCEDURES

13. Colposcopy without Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ Procedure site: _____ Results: <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Clearly defined lesion of CIN <input type="checkbox"/> Abnormal, suspicious for cancer <input type="checkbox"/> Abnormal, but not suspicious for cancer <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refused (Complete Refused/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	14. Colposcopy-directed Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ Procedure site: _____ Results: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III/CIS <input type="checkbox"/> Invasive Carcinoma <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other non-cancerous abnormality <input type="checkbox"/> Refused (Complete Refused/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	15. Other Procedure #1 <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ <input type="checkbox"/> ECC <input type="checkbox"/> LEEP <input type="checkbox"/> Cone <input type="checkbox"/> Other _____ Procedure site: _____ Results: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III/CIS <input type="checkbox"/> Invasive Carcinoma <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other non-cancerous abnormality <input type="checkbox"/> Refused (Complete Refused/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	16. Other Procedure #2 <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ <input type="checkbox"/> ECC <input type="checkbox"/> LEEP <input type="checkbox"/> Cone <input type="checkbox"/> Other _____ Procedure site: _____ Results: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III/CIS <input type="checkbox"/> Invasive Carcinoma <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other non-cancerous abnormality <input type="checkbox"/> Refused (Complete Refused/LTFU Form) Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other
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WORK-UP STATUS

TREATMENT STATUS

17. What is the status of the final diagnosis? <input type="checkbox"/> Work-up complete <input type="checkbox"/> Client lost to follow-up (Complete Refused/LTFU Form) <input type="checkbox"/> Work-up refused (Complete Refused/LTFU Form) <input type="checkbox"/> Irreconcilable	20. What is the status of cervical cancer treatment? <input type="checkbox"/> Treatment started <input type="checkbox"/> Client lost to follow-up (Complete Refused/LTFU Form) <input type="checkbox"/> Treatment refused (Complete Refused/LTFU Form) <input type="checkbox"/> Treatment not recommended
18. Date of final diagnosis: ____ / ____ / ____ (mm/dd/yyyy)	21. Date of treatment status: ____ / ____ / ____ (mm/dd/yyyy)
19. Final diagnosis: <input type="checkbox"/> Normal/Benign Reaction/Inflammation <input type="checkbox"/> HPV/Condylomata/Atypia <input type="checkbox"/> CIN I/Mild Dysplasia (biopsy diagnosis) <input type="checkbox"/> CIN II/Moderate Dysplasia (biopsy diagnosis) <input type="checkbox"/> CIN III/Severe Dysplasia/Carcinoma in situ (Stage 0) (biopsy diagnosis) <input type="checkbox"/> Invasive Cervical Carcinoma (biopsy diagnosis) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Low grade SIL (biopsy diagnosis) <input type="checkbox"/> High grade SIL (biopsy diagnosis)	22. Was client enrolled in Medicaid for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , why not? _____ Form Completed by: _____