State of California—Health and Human Services Agency | California Department of Health Care Services

DETEC - CERVICAL CANCER SCREENING CYCLE DATA

CONFIDENTIAL DATA

Recipient ID# | | | 9 | A | | | | | | | | | | | **Date of Birth** _____/_____/_____ mm/dd/yyyy

Recipient Name: _____ (Last) _____ (First) _____ (Middle)

Provider NPI# _____

I Pap Test

1a. PREVIOUS Pap Test?

- O Yes - Date known
- O Yes - Date unknown but within last 5 years
- O Yes - Date unknown but more than 5 years
- O No
- O Unknown - Woman doesn't know
- O Unknown - Woman wasn't asked / not recorded
- O Unknown - Woman refused to answer

1b. Date of PREVIOUS Pap Test _____/_____ (mm yyyy)

2. Reason for CURRENT Pap Test (See Instruction Sheet)

- O Routine Pap test
- O Pap test for management of previous abnormal result
- O✦Pap test not done - Diagnostic work-up and/or HPV test only
- O✦Pap test not paid by EWC - Client referred for diagnostics only (Report Pap Test result in Item 7)

✦Complete diagnostic referral date *(Item 3)*

(See Instruction Sheet)

3.✦Cervical Diagnostic Referral Date _____/_____/_____ mm/dd/yyyy

4. Date of CURRENT Pelvic Exam _____/_____/_____ (mm dd yyyy)

5. Specimen Adequacy

- O Satisfactory
- O✓Unsatisfactory

6. Specimen Type

- O Conventional Smear
- O Liquid Based
- O Other
- O Unknown

7a. CURRENT Pap Test Result

- O Negative for intraepithelial lesion or malignancy
- O✓Atypical squamous cells of undetermined significance (ASC-US)
- O✓Low grade SIL (LSIL) - including HPV changes
- O* Atypical squamous cells cannot exclude HSIL (ASC-H)
- O* High grade SIL (HSIL)
- O*Squamous Cell Carcinoma
- O*Abnormal Glandular Cells (AGC)
- O*AGC - Neoplastic
- O*Adenocarcinoma In Situ (AIS)
- O*Adenocarcinoma
- O **Other - Please specify** _____

*Immediate work-up needed *(Item 9)*

✓Short term follow-up recommended *(Item 9)*

7b. Date of CURRENT Pap Test _____/_____/_____ (mm dd yyyy)

8a. CURRENT HPV Test Result

- O Test Not Done
- O Positive
- O Negative

(See Instruction Sheet)

8b. Date of CURRENT HPV Test _____/_____/_____ (mm dd yyyy)

II Additional Procedures Needed to Complete Cervical Cycle?

9.

- O Not needed or planned - **Routine rescreen** (Resume routine screenings)
- O✓Not needed or planned - **Short term follow-up** (Next appointment planned within 12 months)
- O* Needed or planned - **Immediate work-up** (Immediate diagnostic work-up is planned)

III Cervical Diagnostic Procedures

• All dates below must be ON or AFTER the Date of CURRENT Pap Test •

10a. Type of Procedure (▲*Covered with restrictions* ▼*Not Covered by* EWC) (See Instruction Sheet)

- O Colposcopy without Biopsy
- O Colposcopy with Biopsy and/or ECC
- O▼Loop Electrosurgical Excision Procedure (LEEP)
- O▼Cold Knife Cone (CKC)
- O▲Endocervical Curettage alone (ECC)

10b. Date of Procedure _____/_____/_____ (mm dd yyyy)

11a. Other Cervical Procedure Performed (▲*Covered with restrictions* ▼*Not Covered by* EWC) (See Instruction Sheet)

- O▲Excision of endocervical polyps
- O▲Endometrial biopsy (EMB)
- O▼Biopsy of other structure (e.g., vagina, vulva)
- O Other gynecologic consults
- O **Other - Please specify** _____

11b. Date of Procedure _____/_____/_____ (mm dd yyyy)

IV Cervical Work-up Status and Final Diagnosis Information

12a. Work-up Status (See Instruction Sheet)

- O Work-up complete
- O Lost to follow-up (Two phone calls and certified letter sent)
- O Work-up refused (Patient refused, obtained insurance, moved, or changed PCP)
- O Died before work-up complete

12b. Date of Work-up Status _____/_____/_____ (mm dd yyyy)

13a. Final Diagnosis

- O Normal / Benign reaction / inflammation
- O HPV / Condylomata / Atypia
- O CIN I / mild dysplasia (biopsy diagnosis)
- O►CIN II / moderate dysplasia (biopsy diagnosis)
- O►CIN III / severe dysplasia / CIS or AIS of cervix (biopsy diagnosis)
- O►Invasive Cervical Carcinoma - Squamous Cell or Adenocarcinoma (biopsy diagnosis)
- O Low grade SIL (biopsy diagnosis)
- O►High grade SIL (biopsy diagnosis)
- O **Other - Please specify** _____

►Treatment Status required if final diagnosis is CIN II, CIN III / CIS / AIS, HSIL or Invasive Cervical Carcinoma *(Item 14)*

13b. Date of Final Diagnosis _____/_____/_____ (mm dd yyyy)

V Cervical Cancer Treatment Information

14a. Treatment Status

- O Treatment started
- O Lost to follow-up (Two phone calls and certified letter sent)
- O Treatment refused
- O Treatment not needed
- O Died before treatment started

14b. Date of Treatment Status _____/_____/_____ (mm dd yyyy)

15. ☐ Patient enrolled in BCCTP. Check this box ONLY if you have completed the BCCTP enrollment process.

Clinician's Signature (optional) _____ **Date** _____