**BREAST & CERVICAL HISTORY/EXAM/SCREENING FORM**

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| --- | --- | --- | --- | --- |
| Please Print  **BCCHP ID#** **Authorization #** | | | | |
| **Last Name:** | **First Name:** | **MI:** | **Date of Birth** | **Date:** |
| **Clinic/Screening Site:** **Provider:       (Patient label may be used in this section)**  **Appt. Date:       Appointment Time:       Clinic Chart #:** | | | | |
| **Health Insurance:**  No Yes: If “Yes”, company:       Policy/ID #:       Deductible Amount: :$ | | | | |

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| --- | --- |
| **Tobacco use:** Current smoker?  Yes  No  Never Smoked If “Yes”, ever counseled to stop?  Yes  No | |
| **What is patient’s gender identity? (Optional)**  Female  Male  Transman  Transwoman  Genderqueer  Gender Non-Binary  Agender  \_\_\_\_\_\_\_\_\_\_\_    **\*\*PROVIDERS MUST Finish SECTIONS BELOW THIS LINE\*\*** | **Disability?**  No  Yes ***Circle all that apply*** Physical, Hearing, Visual, Developmental  Other (specify):  If “Yes”, does this cause difficulty in accessing services?  Yes  No |
| **CERVICAL HEALTH HISTORY** | **BREAST HEALTH HISTORY** |
| **Previous Pap Test?**  Yes  No  Unknown  *If “Yes”, Date of previous Pap test:*  Results:  Normal  Abnormal  Unknown  **Has the patient had a Hysterectomy?**  Yes*, Date of hysterectomy:*        No  Unknown  If “Yes”, reason for hysterectomy:  CIN2/3 or cervical cancer  Not cancer  Unknown  Does pt have a cervix? Yes  No  Unknown  **Personal History** of abnormal Paps?  Yes  No  Unknown  History of HPV?  Yes  No  Unknown  HIV Positive?  Yes  No  Unknown  Did patient’s mother take Diethylstilbestrol (DES) when pregnant with pt?  Yes  No  Unknown  Is patient Immunocompromised due to organ transplant or an autoimmune disease?  Yes  No  Unknown | **Previous Mammogram?**  Yes  No  Unknown  *If “Yes”, Date of previous Mammogram:*  Results:  Normal  Abnormal  Unknown  Does patient have breast implants?  Yes  No  **Family history** of breast cancer 1˚ relative  (Mother, father, sister, brother, daughter or son)?  Yes  No  Unknown *If “Yes”, Age:*  **BRCA 1 or 2** carrier-self  Yes  No  Unknown  **BRCA 1 or 2** 1˚ relative carrier  Yes  No  Unknown  **Personal breast cancer history**?  Yes  No  Unknown *Age:*  Personal history of a pre-cancerous breast condition?  Yes  No  Unknown *If “Yes”, Age :*  Has patient ever given birth?  Yes  No  Age of first full-term pregnancy? |

**BREAST EXAM / SCREENING**

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| **CBE performed:**  Yes  No If “No” reason why:  Not indicated  Refused  Other/Unknown | | | |
| **\*Breast Cancer Risk:**  Average  High  Not Assessed  **Only if high risk,** Tyrer-Cuzick (IBIS) model used**:**  Yes  No **Lifetime Risk:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%** (20% or higher is considered high risk) | | Other tool used(Gail model not accepted by BCCHP):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Indicate if chest wall radiation before 30**  Yes  No | |
| **Reporting symptoms:**  Yes  No If “Yes”, specify: | | | |
| **CBE Results: *Normal / Benign***  Normal  Benign Finding: specify:    Implants  R  L  Mastectomy  R  L | ***Current Suspicious Findings\****  ***Must have diagnostic plan***  Discrete palpable mass  Bloody or serous nipple discharge  Nipple or areolar scaliness  Skin changes (dimpling, retraction, inflammation) | | **Diagnostic Work-Up Plan\***  Diagnostic Mammogram  *\* A mammogram or additional views is not sufficient evaluation of an abnormal CBE. Palpable breast masses need to be evaluated clinically and/or with additional imaging* *regardless of mammogram results.*  Ultrasound  Biopsy  Surgical Consult/Repeat CBE  Fine Needle Aspiration  Cyst Aspiration  Ductogram / Galactogram |
| **Refer for Mammogram:**  Yes  Not indicated  Need other diagnostics  Refused | | |
| **Reason for Mammogram:**  Routine Screen  Evaluate symptoms/abnormal finding, abnormal mammogram  Referred by non-BCCHP provider for diagnostic evaluation  Referred to: | | |

***FAX both pages of this form to the BCCHP Prime Contractor when complete***

**BREAST & CERVICAL HISTORY EXAM/SCREENING FORM**

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| --- | --- | --- | --- | --- |
| |  | | --- | | Please Print **(Patient label may be used in this section)**  **BCCHP ID#       Authorization #** | | | | |
| **Last Name:** | **First Name:** | **MI:** | **Date of Birth** |
| **Clinic/Screening Site:** | | | **Appt. Date:** |

**CERVICAL EXAM / SCREENING**

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| ***Pelvic exam performed:***  Yes  No ***If Pelvic exam not done:***  Refused  Other (Pelvic exam alone does not count as screening) | | | | | |
| **Pelvic Exam: Cervix**  Present  Absent  **Results**  Normal  Inflammation  Unusual discharge  Visible Mass  Infection  Polyp(s) Suspicious Lesions If any exam is suspicious for cervical cancer, diagnostic plan must be noted | | | | | |
| **\*Cervical Cancer Risk:**  Average  High  Not Assessed  If high, indicate reason (refer to cervical history for reference)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Pap Test Performed**  Yes  No ***If Pap Test not done:***  Refused  Other | | | | | |
| **Reason for Pap test:**   Pap test after Primary HPV  Routine Screen  Referred by non-BCCHP provider for diagnostic evaluation  Surveillance (previous abnormal Pap smear)  Referred directly for diagnostic work-up | | | **Pap Test Result: *Suspicious Findings Must Have Diagnostic Plan***  Negative  Adenocarcinoma In Situ (AIS)  ASC-US (Review HPV results)  Adenocarcinoma  LSIL *(work up depends on HPV results)*  Squamous cell Carcinoma  ASC-H: cannot exclude HSIL  Atypical Glandular Cells (AGC)  HSIL Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***See Cervical Policy and ASCCP Guidelines for work up***  If any exam is suspicious for cervical cancer, diagnostic plan must be noted  **Client Counseled/Educated about:**  Risk factors for breast and cervical cancer  Tobacco cessation  Importance of breast and cervical screening exams | | |
| **Pap Test Results: *Specimen Adequacy***  Satisfactory  Unsatisfactory - Do not mark result | | |
| **HPV test performed**  Yes  No ***If HPV not done:***  Refused  Other | | | | | |
| **Reason for HPV test:**  Routine Screen/Co-test  Routine Screen Primary/HPV | | **HPV results**  Negative  Positive  Indeterminate | | **IF HPV test positive, Send for 16/18 Genotyping.**  If HPV 16 or 18 positive and pap negative, refer for colposcopy.  Negative for 16 and 18  Positive for 16 or 18  Indeterminate | |
| **Work-Up Plan\***  Consultation  Colposcopy with Biopsy | Colposcopy with Biopsy and ECC  Colposcopy with ECC  Endometrial Biopsy with or w/o ECC | | | | **The following procedures require Prior Authorization:**   1. Diagnostic LEEP 2. Diagnostic Conization (i.e. CKC) |

**Provider Comments**

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| **Preventive Office Services:**  99385-new client (18-39 years old)  99386-new client (40-64 years old)  99387-new client (65+ years old)  99395-established client (18-39 years old)  99396-established client (40-64 years old)  99397-established client (65+ years old) | | **Office Services:**  99201-new client, problem-focused, straightforward (10 minutes)  99202-new client, expanded-focused, straightforward (20 minutes)  99203-new client, detailed, low complexity, straightforward (30 minutes)  99211-established client, problem-focused, straightforward (5 minutes)  99212-establsihed client, expanded-focused, straightforward (10 minutes)  99213-establsihed patient-expanded focused, low complexity (15 minutes)  99214-established patient-detailed, moderate complexity (25 min) | | |
| DIAGNOSTIC PROVIDER SIGNATURE | Print Name | | Telephone Number | Date |

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**REIMBURSEMENT REQUEST FOR SERVICES (*FAX both pages of this form to the Prime Contractor when complete)***