

## BREAST & CERVICAL HISTORY/EXAM/SCREENING FORM

Please Print (Patient label may be used in this section)

BCCHP ID#

Authorization #

<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>	<b>Date of Birth:</b>
<b>Clinic/Screening Site:</b>		<b>Provider:</b>	
<b>Appt. Date:</b>	<b>Appointment Time:</b>	<b>Clinic Chart #:</b>	

**Tobacco use:** Current smoker?  Yes  No  Never Smoked If current smoker, was patient ever counseled to stop?  Yes  No

**Client counseled/educated about:**

Risk factors for breast and cervical cancer  Importance of breast and cervical screening exams  Tobacco cessation

**Providers/clinic staff must complete ALL sections below this line:**

CERVICAL HEALTH HISTORY/RISK ASSESSMENT	BREAST HEALTH HISTORY/RISK ASSESSMENT
<p><b>Previous Pap Test?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <i>If "Yes", Date of previous Pap test:</i>            Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown</p> <p><b>Previous HPV Test?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <i>If "Yes", date of previous HPV test:</i>            Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown</p> <p><b>Has the patient had a Hysterectomy?</b>  <input type="checkbox"/> Yes <i>Date of hysterectomy:</i> <input type="checkbox"/> No <input type="checkbox"/> Unknown  <i>If "Yes", reason for hysterectomy:</i>  <input type="checkbox"/> CIN2/3 or cervical cancer <input type="checkbox"/> Not cancer <input type="checkbox"/> Unknown</p> <p><b>Cervix:</b> <input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Unknown</p> <p><b>Personal History</b>            Abnormal Paps? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown            History of HPV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown            HIV Positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown            Did patient's mother take Diethylstilbestrol (DES) when pregnant with patient?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown            Is patient Immunocompromised due to organ transplant or an autoimmune disease?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>*Cervical Cancer Risk:</b> <input type="checkbox"/> Average <input type="checkbox"/> High  <b>If high, indicate reason:</b> _____            _____</p>	<p><b>Previous Mammogram?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <i>Date of previous Mammogram:</i>            Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown            Does patient have breast implants? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Family history</b> of breast cancer 1° relative            (Parents, siblings, or children)?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>If "Yes", Age:</i>  <b>BRCA 1 or 2</b> carrier-self <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <b>BRCA 1 or 2</b> 1° relative carrier <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <b>Personal breast cancer history?</b> <input type="checkbox"/> Yes <i>Age:</i> <input type="checkbox"/> No <input type="checkbox"/> Unknown            Personal history of a pre-cancerous breast condition?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>If "Yes", Age:</i>            Has patient ever given birth? <input type="checkbox"/> Yes <input type="checkbox"/> No            Age of first full-term pregnancy?  <b>Indicate if chest wall radiation before 30</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>*Breast Cancer Risk:</b> <input type="checkbox"/> Average <input type="checkbox"/> High  <b>If high, Tyrer-Cuzick (IBIS) model used:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No            Other tool used (Gail model not accepted by BCCHP): _____</p> <p><b>Lifetime Risk:</b> _____% (20% or higher is considered high risk)</p>

**If sending with patient chart notes, stop here and go to Reimbursement Request (pg 3).  
 If chart notes are not available, fill out Breast and/or Cervical Exam page below.**

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**BREAST EXAM**

<b>CBE performed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "No" reason why: <input type="checkbox"/> Not indicated <input type="checkbox"/> Refused <input type="checkbox"/> Other/Unknown	
<b>Reporting symptoms:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", specify:	
<b>CBE Results:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Benign Finding ( <i>specify</i> ): <input type="checkbox"/> Implants <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Mastectomy <input type="checkbox"/> R <input type="checkbox"/> L	
<b>Current Suspicious Findings* (MUST have diagnostic plan)</b> <input type="checkbox"/> Discrete palpable mass <input type="checkbox"/> Bloody or serous nipple discharge <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Skin changes (dimpling, retraction, inflammation)  <i>*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.</i>	<b>Diagnostic Work-Up Plan*</b> <input type="checkbox"/> Diagnostic Mammogram* <input type="checkbox"/> Ultrasound <input type="checkbox"/> Biopsy <input type="checkbox"/> Surgical Consult/Repeat CBE <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Ductogram / Galactogram
<b>Refer for Mammogram:</b> <input type="checkbox"/> Yes <input type="checkbox"/> Not indicated <input type="checkbox"/> Need other diagnostics <input type="checkbox"/> Refused	<b>Referred to:</b>
<b>Reason for Mammogram:</b> <input type="checkbox"/> Routine Screen <input type="checkbox"/> Evaluate symptoms/abnormal finding, abnormal mammogram <input type="checkbox"/> Referred by non-BCCHP provider for diagnostic evaluation	

**CERVICAL EXAM**

<b>PELVIC EXAM (Pelvic exam alone does not count as screening)</b>	
<b>Pelvic Exam Results (If any exam is suspicious for cervical cancer, diagnostic plan must be noted)*:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Inflammation <input type="checkbox"/> Unusual discharge <input type="checkbox"/> Visible Mass <input type="checkbox"/> Infection <input type="checkbox"/> Polyp(s) <input type="checkbox"/> Suspicious Lesions	
<b>PAP TEST</b>	
<b>Pap Test Results: Specimen Adequacy</b> <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory - Do not mark result	
<b>Pap Test Result: (Suspicious Findings Must Have Diagnostic Plan)*</b> <input type="checkbox"/> Negative <input type="checkbox"/> Adenocarcinoma In Situ (AIS) <input type="checkbox"/> ASC-US (Review HPV results) <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> LSIL ( <i>work up depends on HPV results</i> ) <input type="checkbox"/> Squamous cell Carcinoma <input type="checkbox"/> ASC-H: cannot exclude HSIL <input type="checkbox"/> Atypical Glandular Cells (AGC) <input type="checkbox"/> HSIL <input type="checkbox"/> Other _____	
<b>HPV TEST</b>	
<b>HPV Test Type:</b> <input type="checkbox"/> Provider Performed <input type="checkbox"/> Self-Collected	
<b>HPV results:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate	
<b>IF HPV test positive, send for 16/18 Genotyping.</b> If HPV 16 or 18 positive and pap negative, refer for colposcopy. <input type="checkbox"/> Negative for 16 and 18 <input type="checkbox"/> Positive for 16 or 18 <input type="checkbox"/> Indeterminate	
<b>WORK-UP PLAN*</b>	
<b>*See Cervical Policy and ASCCP Guidelines for work up.</b> If any exam is suspicious for cervical cancer, diagnostic plan MUST be noted. <input type="checkbox"/> Consultation <input type="checkbox"/> Colposcopy with Biopsy and ECC <input type="checkbox"/> Endometrial Biopsy with OR without ECC <input type="checkbox"/> Colposcopy with Biopsy <input type="checkbox"/> Colposcopy with ECC	
<b>The following procedures require PRIOR AUTHORIZATION:</b> <input type="checkbox"/> Diagnostic LEEP <input type="checkbox"/> Diagnostic Conization (i.e., CKC)	

(Form continued on next page)

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**Provider Comments:**

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**REIMBURSEMENT REQUEST FOR SERVICES**

**Preventive Office Services:**

- 99385–New Patient - Initial Comprehensive Eval/Mgmt, 18-39 yrs
- 99386–New Patient - Initial Comprehensive Eval/Mgmt, 40-64 yrs
- 99387–New Patient - Initial Comprehensive Eval/Mgmt, 65+ yrs
- 99395–Established - Periodic Comprehensive Eval/Mgmt, 18-39 yrs
- 99396–Established - Periodic Comprehensive Eval/Mgmt, 40-64 yrs
- 99397–Established - Periodic Comprehensive Eval/Mgmt, 65+ yrs

**Telehealth Services:**

- 99441–Physician/Qualified Health Prof Telephone Eval, 5-10 min
- 99442–Physician/Qualified Health Prof Telephone Eval, 11-20 min
- 99443–Physician/Qualified Health Prof Telephone Eval, 21-30 min

**Office Services:**

- 99202–New Patient - Straightforward, 15-29 min
- 99203–New Patient - Low Complexity, 30-44 min
- 99204–New Patient - Moderate Complexity, 45-59 min
- 99205–New Patient - High Complexity, 60-74 min
- 99211–Established Patient - Minimal Problem(s)
- 99212–Established Patient - Straightforward, 10-19 min
- 99213–Established Patient - Low Complexity, 20-29 min
- 99214–Established Patient - Moderate Complexity, 30-39 min

<b>DIAGNOSTIC PROVIDER SIGNATURE</b>	Print Name	Telephone Number	Date
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**FAX all pages of this form and any included exam/chart notes to the Prime Contractor when complete.**