Washington State Department of Health

DOH 342-057 Sept 2021

Public Health Seattle & King County
Breast Cervical & Colon Health Program
401 5th Ave #1110, Seattle WA 98104
T 206-263-8176 F 206-296-0208

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

BREAST & CERVICAL HISTORY/EXAM/SCREENING FORM

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: :$

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 ☐ _____

Disability? ☐ No ☐ Yes ***Circle all that apply*** Physical, Hearing, Visual, Developmental ☐ Other (specify):
If "Yes", does this cause difficulty in accessing services? ☐ Yes ☐ No

****PROVIDERS MUST Finish SECTIONS BELOW THIS LINE****

CERVICAL 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

BREAST HEALTH HISTORY

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

CBE performed: ☐ Yes ☐ No If "No" reason why: ☐ Not indicated ☐ Refused ☐ Other/Unknown

***Breast Cancer Risk:** ☐ Average ☐ High ☐ Not Assessed
Other tool used (Gail model not accepted by BCCHP):_____
Only if high risk, Tyrer-Cuzick (IBIS) model used: ☐ Yes ☐ No
Indicate if chest wall radiation before 30 ☐ Yes ☐ No
Lifetime Risk:_____**%** (20% or higher is considered high risk)

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

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Clinic/Screening Site:			**Appt. Date:**

CERVICAL EXAM / SCREENING

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 Results: ***Specimen Adequacy***
☐ Satisfactory
☐ Unsatisfactory - Do not mark result

Pap Test Result: ***Suspicious Findings Must Have Diagnostic Plan***
☐ Negative
☐ ASC-US (Review HPV results)
☐ LSIL *(work up depends on HPV results)*
☐ ASC-H: cannot exclude HSIL
☐ HSIL
☐ Adenocarcinoma In Situ (AIS)
☐ Adenocarcinoma
☐ Squamous cell Carcinoma
☐ Atypical Glandular Cells (AGC)
☐ 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

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 <u>Prior Authorization:</u>
1. ☐ Diagnostic LEEP
2. ☐ Diagnostic Conization (i.e. CKC)

Provider Comments

_____

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

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

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