**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 [ ]  UnknownHistory of HPV? [ ]  Yes [ ]  No [ ]  Unknown HIV Positive? [ ]  Yes [ ]  No [ ]  UnknownDid patient’s mother take Diethylstilbestrol (DES) when pregnant with pt? [ ]  Yes [ ]  No [ ]  UnknownIs 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 [ ]  UnknownDoes 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 evaluationReferred 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 #**  |

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| **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)
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 **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-new 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)***