Maine Breast and Cervical Health Program (MBCHP)

Abnormal Cervical Screening Follow-Up Report

PCP Site:_____ Date of abnormal screening exam: ____ / ____ / _____

Patient Name (Last, First, M. I.):_____

REASONS FOR DIAGNOSTIC WORK-UP (check all that apply)

- ❑ Abnormal Pelvic Exam
- ❑ Abnormal Pap test
- ❑ Client concern
- ❑ Primary Care Provider concern

DIAGNOSTIC PROCEDURES (check all that apply)

❑ Surgical Consult	Date: ____ /____ /_____	Provider: _____
❑ GYN Consult	Date: ____ /____ /_____	Provider: _____
❑ Colposcopy w/out biopsy	Date: ____ /____ /_____	Provider: _____
❑ Colpo w/ biopsy and/or ECC	Date: ____ /____ /_____	Provider: _____
❑ Endocervical curettage (ECC) only	Date: ____ /____ /_____	Provider: _____
❑ Removal of cervical polyp	Date: ____ /____ /_____	Provider: _____
❑ LEEP**	Date: ____ /____ /_____	Provider: _____
❑ Conization of cervix**	Date: ____ /____ /_____	Provider: _____
❑ Other _____	Date: ____ /____ /_____	Provider: _____

** Non-covered diagnostic procedure

STATUS OF DIAGNOSIS

- ❑ Work-Up Complete with Recommended Rescreening Date: _____ / _____ /_____
- ❑ Work-Up Refused (Date: _____ /_____/_____)
- ❑ Lost to Follow-Up (Date: _____ / _____ /_____)
- ❑ Work-Up Irreconcilable with Recommended Rescreening Date: _____ / _____ /_____

FINAL DIAGNOSIS **Date of final diagnosis: _____ / _____/ _____** *****requires treatment***

- ❑ Normal/Benign reaction/inflammation
- ❑ HPV/Condylomata/Atypia
- ❑ CINI/mild dysplasia (biopsy diagnosis)
- ❑ **CINII/moderate dysplasia (biopsy diagnosis)
- ❑ **CINIII/severe dysplasia/Carcinoma in situ (Stage 0) or Adenocarcinoma In Situ of the cervix (AIS) (biopsy diagnosis)
- ❑ Low grade SIL (biopsy diagnosis)
- ❑ **High grade SIL (biopsy diagnosis)
- ❑ Other diagnosis (specify):_____
- ❑ **Invasive cervical carcinoma (biopsy diagnosis)
  - Tumor Stage: _____
  - Tumor Size: _____

❑ *Request MBCHP Case Management for assistance in managing patient care*

TREATMENT

❑ Treatment started/will start Treatment Procedure: _____
Date: ____ /____ /_____ Provider: _____

❑ Treatment refused Date: _____ /_____ /_____

❑ Lost to follow-up Date: _____ /_____ /_____
(includes deceased)

NOTES: _____

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