

*PC Logo/Information here*

DOH 349-046 Sept 2021

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| **NAVIGATION CONTACT FORM** |
|  |
| **Last Name**:       **First Name**:       **Middle Initial**:      **Date of Birth**: Click or tap to enter a date. |
| *Please fill in Section 2 for all clients and any additional numbered sections, as applicable.* |
| **Client Type:** [ ]  BCCHP Client **Med-It # (if known):**      [ ]  Navigation-Only Client — *complete information in Section (1)* | **Navigation Received:** *Numbers in () indicate sections to complete as applicable.*[ ]  Breast Screening (3) [ ]  Breast Diagnostics (4) [ ]  Breast Treatment (4)[ ]  Cervical Screening (3) [ ]  Cervical Diagnostics (4) [ ]  Cervical Treatment (4) |
| **1. ADDITIONAL CLIENT DEMOGRAPHICS (Non-BCCHP Clients)** |
| **Phone Number**:        **Email**:     **Home Address**:      **Apt#**:     **City**:      **ZIP Code**:      |
| **Preferred Language**: Choose an item. **Preferred Method of Contact**: Choose an item.**Insurance Status**: [ ]  No [ ]  Yes **Ethnicity**: Choose an item. **Race(s):** [ ]  American Indian/Alaska Native [ ]  Asian [ ]  Black/African American [ ]  Native Hawaiian/Pacific Islander [ ]  Caucasian/White/Blanca[ ]  Other (specify):      |
| **2. NAVIGATION CONTACTS (All Clients)** |
| **First Contact Date:** | Click or tap to enter a date. | **Type of Contact:** Choose an item. |
| **Second Contact Date:**  | Click or tap to enter a date. | **Type of Contact:** Choose an item. |
| **Additional Contact Date:** | Click or tap to enter a date. | **Type of Contact:** Choose an item. |
| **Additional Contact Date:** | Click or tap to enter a date. | **Type of Contact:** Choose an item. |
| **Additional Contact Date:** | Click or tap to enter a date. | **Type of Contact:** Choose an item. |
| **Barriers Identified:** [ ] No Medical Provider [ ]  Trouble scheduling appt. [ ]  Financial Concerns [ ]  Transportation[ ]  Language Barriers/Interpreter Needed [ ]  Belief they won’t get cancer [ ]  Concerns about screening/diagnostic procedure [ ]  Concerns about cultural sensitivity [ ]  Upset with an experienced lack of cultural sensitivity[ ]  Other (specify)      |
| **3. SCREENING SERVICES (If Applicable)** |
| **Screening Mammogram Date:** Click or tap to enter a date. | **Results:** Choose an item. |
| **Screening MRI Date:** Click or tap to enter a date.  | **Results:** Choose an item. |
| **HPV Test Date:** Click or tap to enter a date.  | **HPV Results:** Choose an item. |
| **Pap Test Date:** Click or tap to enter a date.  | **Pap Results:** Choose an item. |
| **4. DIAGNOSTIC/TREATMENT SERVICES (If Applicable)** |
| **Date Diagnostic Services Provided:** Click or tap to enter a date. | **Treatment Start Date:** Click or tap to enter a date. |
| **Breast Final Diagnosis:** Choose an item. | **If “Other” selected, please specify:**       |
| **Cervical Final Diagnosis:** Choose an item. | **If “Other” selected, please specify:**       |

**Navigation Complete:**  [ ]  Yes [ ]  No  **Reason not completed:**

**Navigator:** **Organization:** **Date:** Click or tap to enter a date.