**BREAST & CERVICAL HISTORY/EXAM/SCREENING FORM**

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| Please Print (Patient label may be used in this section) **BCCHP ID#** **Authorization #**  |
| **Last Name:**      | **First Name:**      | **MI:**      | **Date of Birth:**      |
| **Clinic/Screening Site:** **Provider:****Appt. Date:       Appointment Time:       Clinic Chart #:** |

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| **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** |
| **Previous Pap Test?**[ ]  Yes [ ]  No [ ]  Unknown*If “Yes”, Date of previous Pap test:*       Results: [ ]  Normal [ ]  Abnormal [ ]  Unknown**Previous HPV Test?**[ ]  Yes [ ]  No [ ]  Unknown*If “Yes”, date of previous HPV 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**Cervix**: [ ]  Present [ ]  Absent [ ]  Unknown**Personal History**Abnormal Paps? [ ]  Yes [ ]  No [ ]  UnknownHistory of HPV? [ ]  Yes [ ]  No [ ]  Unknown HIV Positive? [ ]  Yes [ ]  No [ ]  UnknownDid patient’s mother take Diethylstilbestrol (DES) when pregnant with patient? [ ]  Yes [ ]  No [ ]  UnknownIs patient Immunocompromised due to organ transplant or an autoimmune disease? [ ]  Yes [ ]  No [ ]  Unknown**\*Cervical Cancer Risk**: [ ]  Average [ ]  High **If high, indicate reason**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | **Previous Mammogram?**[ ]  Yes [ ]  No [ ]  Unknown*Date of previous Mammogram:*      Results: [ ]  Normal [ ]  Abnormal [ ]  UnknownDoes patient have breast implants? [ ]  Yes [ ]  No**Family history** of breast cancer 1˚ relative (Parents, siblings, or children)? [ ]  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 *Age:* [ ]  No [ ]  UnknownPersonal 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?    **Indicate if chest wall radiation before 30** [ ]  Yes [ ]  No **\*Breast Cancer Risk:** [ ]  Average [ ]  High**If high,** Tyrer-Cuzick (IBIS) model used**:** [ ]  Yes [ ]  NoOther tool used(Gail model not accepted by BCCHP):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Lifetime Risk:\_\_\_\_\_\_\_%** (20% or higher is considered high risk)  |

**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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|  **BCCHP ID# Authorization #**  |
| **Last Name:**  | **First Name:**  | **MI:**  | **Date of Birth:**  |

**BREAST EXAM**

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| **CBE performed:** [ ]  Yes [ ]  No If “No” reason why: [ ]  Not indicated [ ]  Refused [ ]  Other/Unknown |
| **Reporting symptoms:** [ ]  No [ ]  Yes If “Yes”, specify:       |
| **CBE Results:**  | [ ]  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)*\*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.* | **Diagnostic Work-Up Plan\***[ ]  Diagnostic Mammogram\* [ ]  Ultrasound [ ]  Biopsy[ ]  Surgical Consult/Repeat CBE [ ]  Fine Needle Aspiration[ ]  Cyst Aspiration[ ]  Ductogram / Galactogram |
| **Refer for Mammogram:** | [ ]  Yes [ ]  Not indicated [ ]  Need other diagnostics [ ]  Refused | **Referred to:**       |
| **Reason for Mammogram:** | [ ]  Routine Screen [ ]  Evaluate symptoms/abnormal finding, abnormal mammogram[ ]  Referred by non-BCCHP provider for diagnostic evaluation |

**CERVICAL EXAM**

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| **PELVIC EXAM (***Pelvic exam alone does not count as screening***)** |
| **Pelvic Exam Results** *(If any exam is suspicious for cervical cancer, diagnostic plan must be noted)\**:[ ]  Normal [ ]  Inflammation [ ]  Unusual discharge [ ]  Visible Mass [ ]  Infection [ ]  Polyp(s) [ ]  Suspicious Lesions  |
| **PAP TEST** |
| **Pap Test Results: *Specimen Adequacy*** [ ]  Satisfactory [ ]  Unsatisfactory - Do not mark result |
| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HPV TEST** |
| **HPV Test Type:** [ ]  Provider Performed [ ]  Self-Collected**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\*** |
| ***\*See Cervical Policy and ASCCP Guidelines for work up.*** If any exam is suspicious for cervical cancer, diagnostic plan MUST be noted. |
| [ ]  Consultation[ ]  Colposcopy with Biopsy  | [ ]  Colposcopy with Biopsy and ECC[ ]  Colposcopy with ECC | [ ]  Endometrial Biopsy with OR without ECC |
| **The following procedures require PRIOR AUTHORIZATION:** [ ]  Diagnostic LEEP [ ]  Diagnostic Conization (i.e., CKC) |

*(Form continued on next page)*

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**Provider Comments:**

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**REIMBURSEMENT REQUEST FOR SERVICES**

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| **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 |
| DIAGNOSTIC PROVIDER SIGNATURE | Print Name      | Telephone Number      | Date      |

**FAX all pages of this form and any included exam/chart notes to the Prime Contractor when complete.**