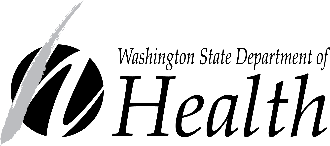


*PC Logo/Information here*



DOH 349-046 Sept 2021

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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.