

Clinic use only

Patient ID number (<i>provider's record number</i>) :	Enrollment date: / /
Enrolling agency and site:	
Was patient referred to OregonHealthcare.gov to determine potential eligibility for health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , referral date: / /

Patient information

Last name(s):	First name:	Middle initial:
Date of birth: / /	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Home address:		Apartment number:
City:	State:	ZIP: County:
Phone:		Email:
Other name(s) used: (<i>Last</i>)		(<i>First</i>)

Alternate contact information (*in case we cannot reach you*)

Name:	Relationship to you:
Address:	Apartment number:
City:	State: ZIP: Phone:

Eligibility information

Do you have health insurance or Medicaid? Yes No
 If **yes**, is the following TRUE?
 My health insurance plan does not fully cover breast and cervical cancer screening services, like mammograms and/or Pap tests. Yes No
 My out-of-pocket costs for diagnostic services pose a financial hardship. Yes No

What is your gross monthly household income?
(This is the total income before taxes for all household members.):

How many people live in your household (*including yourself*)?:

Demographic information (*collecting this information to better serve you*)

Hispanic or Latino origin:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to answer
Ashkenazi Jewish origin:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to answer
Language preference:	
Race: <i>(choose one or more)</i>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White
	<input type="checkbox"/> Asian <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Black or African-American <input type="checkbox"/> Unknown
	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Decline to answer
If you chose more than one race, which do you consider your primary race?	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> No primary race identity
	<input type="checkbox"/> Asian <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Black or African-American <input type="checkbox"/> Unknown
	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Decline to answer
	<input type="checkbox"/> White
Disability (<i>check all that apply; optional</i>):	<input type="checkbox"/> Physical/mobility <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Intellectual/cognitive Other: _____

Client consent

By enrolling in the ScreenWise Program, I agree to what is written on this form:

- ScreenWise can pay for breast and cervical cancer screening and diagnostics and may pay for screening services related to heart disease and stroke, if my provider is enrolled to offer these services.
- ScreenWise does not pay for cancer treatment and I may have to pay for tests and treatment that ScreenWise does not cover.
- Being eligible for breast and cervical cancer screening and diagnostic services does not guarantee that I will also receive screening services related to heart disease and stroke.
- I do not have Medicaid, Medicare, or other insurance that will pay for these screening tests.
- ScreenWise has rules about who may enroll in the program. All of the information I have given to the clinic is true as far as I know. If I tell the clinic something that is not true, I may not get these tests and I may have to pay for any tests done.
- ScreenWise, my medical care providers, clinics and/or hospitals may share information with one another about my health care and any related medical care I receive through ScreenWise; and may organize my care and involvement in health coaching, evidence-based lifestyle programs and the Oregon Tobacco Quit Line.
- My information will not be shared with anyone outside of ScreenWise contracted providers and its funders. Any published report will not use my name.
- I understand that I have the right to withdraw from the ScreenWise program by informing my healthcare provider in writing. I understand that any information shared prior to my withdrawal shall be kept by ScreenWise.
- I understand that I may get letters in the mail from my doctor to remind me when it is time for me to go back to my clinic for screening or other tests.
- This enrollment form expires one year after the date I sign it, meaning that I must re-enroll after 12 months to keep getting services.

Client signature:

Date:

Client name (*printed*):

Interpreter signature (*if used*):

Date:

Screening Form

Patient Name: (Last) _____ (First) _____ Date of Birth _____

Enrolling Agency and Site: _____ Patient ID: _____

MEDICAL HISTORY

Have you or any of your relatives ever been diagnosed with any of the following cancers: breast, male breast, melanoma, ovarian, pancreatic, or prostate?		Relationship (e.g. mother) _____ Type of Cancer _____ Age when diagnosed _____ mothers side or father's side	Relationship (e.g. mother) _____ Type of Cancer _____ Age when diagnosed _____ mothers side or father's side
Do you use tobacco (cigarettes, chew, e-cigarettes, cigars)?		Yes	No
Does anyone in your home use tobacco or smoke in the home?		Yes	No
Have you ever thought about quitting, or have you tried to quit in the past?		Yes	No
Cervical		Breast	
If only cervical services were provided, select the reason:	Patient refused breast services Patient needs cervical services only Already done by another provider Not eligible	If only breast services were provided, select the reason:	Patient refused cervical services Patient needs breast services only Already done by another provider Not eligible
Prior Pap done?	Yes No Unknown	Prior mammogram?	Yes No Unknown
If yes, date of prior Pap	/ (month and year)	If yes, date of prior mammogram	/ (month and year)
		Is client reporting recent breast symptoms?	Yes No Unknown
		Breast symptoms reported	Bloody nipple discharge Dimpling Ulceration Inflammation of the skin Pain Lump/mass Other:

OFFICE VISIT

Cervical		Breast	
Pelvic Exam performed?	Yes – at this clinic Yes – at another clinic or patient referred in for diagnostic evaluation No – normal exam within recommended screening period No – patient refused No – unable to perform at this time	Clinical Breast Exam (CBE) performed?	Yes – at this clinic Yes – at another clinic or patient referred in for diagnostic evaluation (<i>report results if known</i>) No – patient refused No – not needed
Date of exam	/ /	CBE Date	/ /
Pelvic Result	Normal Abnormal, NOT suspicious for cancer Abnormal, suspicious for cancer	CBE Result (check all that apply)	Normal exam Benign finding Bloody or serous nipple discharge Discrete palpable mass – suspicious for cancer Previously diagnosed benign Nipple/areolar scaliness Skin dimpling or retraction Inflammation
Pap Collected?	Yes – at this clinic Yes – at another clinic or patient referred in for diagnostic evaluation (<i>report results below if known</i>) No – normal pap within recommended period No – Hysterectomy, no cervical stump, no history of CIN II or worse No – patient proceeded directly for diagnostic work-up or HPV test No – patient refused No – unknown why	Mammogram Ordered?	Yes – at this clinic Yes – at another clinic or patient referred in for diagnostic evaluation (<i>report results if known</i>) No – normal mammogram within recommended period No – Mastectomy

Continued on Page 2

Screening Form

Patient Name: (Last) _____ (First) _____ Date of Birth _____

Indication for Pap	Routine Pap test Patient has a previous abnormal test Unknown	Mammogram Ordered? <i>(continued)</i>	No – patient only received CBE No – patient proceeded directly for other imaging or diagnostic work No – patient refused No – lost to follow-up
Date of Pap	/ /	Indication for initial mammogram	Routine screening mammography Done to evaluate symptoms, positive CBE, or previous abnormal mammogram Unknown
Specimen Type	Conventional smear Liquid-based Other Unknown		

RESULTS

Cervical		Breast	
Pap	Adequacy	Satisfactory Specimen not processed Unsatisfactory Unknown	Mammogram Date: / /
	Result:	Negative for intraepithelial lesion or malignancy ASC-US LSIL (including HPV changes) ASC-H HSIL (with features suspicious for invasion) Squamous Cell Carcinoma Abnormal Glandular Cells (including atypical, endocervical adenocarcinoma in situ, and adenocarcinoma) Result pending Result unknown, presumed abnormal, Pap test performed by a different provider Other: _____	Procedure Location: Result: BIRADS 1 – Negative BIRADS 2 – Benign finding BIRADS 3 – Probably benign – Initial short interval follow-up suggested BIRADS 4 – Suspicious abnormality; biopsy should be considered BIRADS 5 – Highly suggestive of malignancy; action should be taken BIRADS 0 – Assessment incomplete, needs additional imaging evaluation BIRADS 0 – File comparison required Unsatisfactory – Mammogram was technically unsatisfactory and could not be interpreted by radiologist Result pending Result unknown/presumed abnormal – Mammogram from a different provider
HPV test	HPV (high risk) test done?	Yes No Unknown	
	Location sent to:		
	Result:	Positive Negative	
	Date:	/ /	
Pap		Mammogram	

NEXT STEPS:

Cervical		Breast	
Follow-up Recommendation	Follow routine screening Short-term follow-up _____ Months Repeat Pap test Additional diagnostic procedures <i>(select one)</i> Colposcopy without biopsy Colposcopy with biopsy and/or ECC Endocervical curettage (ECC) alone HPV test (high risk) Gynecological consultation Other procedure not covered by ScreenWise	Follow-up Recommendation	Follow routine screening Short-term follow-up _____ Months Repeat Mammogram Additional diagnostic procedures <i>(select one)</i> CBE by consult Diagnostic mammogram Ultrasound Surgical consult Biopsy FNA/Cyst aspiration

Abnormal Follow-Up Form

Patient Name: (Last) _____ (First) _____ Date of Birth _____
 Enrolling Agency or Site: _____ Patient ID: _____

Additional Diagnostic Procedures

Cervical		Breast	
Date of 1 st Procedure:	/ /	Date of 1 st Procedure:	/ /
Procedure Location:		Procedure Location:	
Type	Colposcopy without biopsy Colpo with biopsy and/or ECC LEEP Cold Knife Cone (CKC) Endocervical curettage (ECC) alone HPV test (high risk) Gynecological consultation Other: _____	Type	Repeat CBE/Surgical Consultation Additional mammography views Ultrasound Biopsy/Lumpectomy FNA/Cyst aspiration Film comparison Other: _____
Result	Normal/benign Needs additional diagnostic work-up Precancer (CIN I/II/III) Cancer	Result	Normal / benign Needs additional diagnostic work-up Cancer
Follow-up Recommendation	Follow routine screening Short-term follow-up _____ months Additional diagnostic procedures (select one) Colposcopy without biopsy Colpo with biopsy and/or ECC Endocervical curettage (ECC) alone Gynecological consultation Other procedure not covered by ScreenWise Colpo unsatisfactory: LEEP Colpo unsatisfactory : Cold Knife Cone (CKC) Final diagnosis and treatment	Follow-up Recommendation	Follow routine screening Short-term follow-up _____ months Additional diagnostic procedures (select one) CBE by consult Diagnostic mammogram Ultrasound Surgical consult Biopsy FNA / Cyst aspiration Final diagnosis and treatment
Date of 2 nd Procedure:	/ /	Date of 2 nd Procedure:	/ /
Procedure Location:		Procedure Location:	
Type	Colposcopy without biopsy Colposcopy with biopsy and/or ECC Loop Electrosurgical Excision Procedure (LEEP) Cold Knife Cone(CKC) Endocervical curettage (ECC) alone HPV test (high risk) Gynecological consultation Other procedure: _____	Type	Repeat CBE/Surgical Consultation Additional mammography views Ultrasound Biopsy/Lumpectomy FNA/Cyst aspiration Film comparison Other procedure _____
Result	Normal/benign Needs additional diagnostic work-up Precancer (CIN I/II/III) Cancer	Result	Normal / benign Needs additional diagnostic work-up Cancer
Follow-up Recommendation	Follow routine screening Short-term follow-up _____ months Additional diagnostic procedures Colposcopy without biopsy	Follow-up Recommendation	Follow routine screening Short-term follow-up _____ months Additional diagnostic procedures CBE by consult

continued on page 2 →

continued on page 2 →

Abnormal Follow-Up Form

Patient Name: (Last) _____ (First) _____ Date of Birth _____

Follow-up Recommendation <i>(continued)</i>	Colpo with biopsy and/or ECC Endocervical curettage (ECC) <i>alone</i> Gynecological consultation Other procedure not covered by ScreenWise Colpo unsatisfactory : LEEP Colpo unsatisfactory : Cold Knife Cone (CKC) Final diagnosis and treatment	Follow-up Recommendation <i>(continued)</i>	Diagnostic mammogram Ultrasound Surgical consult Biopsy FNA / Cyst aspiration Final diagnosis and treatment
		Assessment from all imaging procedures	BIRADS 1 – Negative BIRADS 2 – Benign finding BIRADS 3 – Probably benign – Initial short interval follow-up suggested BIRADS 4 – Suspicious abnormality; biopsy should be considered BIRADS 5 – Highly suggestive of malignancy Unsatisfactory – Mammogram was technically unsatisfactory and could not be interpreted by radiologist Additional imaging pending

Final Diagnosis

Cervical		Breast	
Date of final diagnosis	(If cancer diagnosis, this is the date of procedure in which cancer was diagnosed)	Date of final diagnosis	(If cancer diagnosis, this is the date of procedure in which cancer was diagnosed)
Status	Complete Pending Lost to follow-up Work-up refused Deceased None of the above	Status	Complete Pending Lost to follow-up Work-up refused Deceased None of the above
Final Diagnosis	Normal/Benign reaction/Inflammation HPV/Condylomata/Atypia CIN I/ Mild dysplasia (biopsy diagnosis) CIN II/ Moderate dysplasia (biopsy diagnosis) CIN III/ Severe dysplasia/Carcinoma in situ (Stage 0) (biopsy diagnosis) Invasive cervical carcinoma (biopsy diagnosis) Other: _____	Final Diagnosis	Breast cancer not diagnosed Invasive breast cancer Lobular Carcinoma In Situ (LCIS) – Stage 0 Ductal Carcinoma In Situ (DCIS) – Stage 0

Treatment

Referred to Breast and Cervical Cancer Treatment Program (BCCTP)?	Yes	No	Referred to Breast and Cervical Cancer Treatment Program (BCCTP)?	Yes	No
Status	Treatment started date: _____ Lost to follow-up Treatment refused Not needed		Status	Treatment started date: _____ Lost to follow-up Treatment refused Not needed	