PUBLIC HEALTH DIVISION
ScreenWise Program

Formulario de Inscripción Anual

Oregon Health Authority

Clinic use only/ Para el uso exclusivo de la clínica	
Patient ID number (*provider's record number*) :	Enrollment date: / /
Enrolling agency and site:	
Was patient referred to OregonHealthcare.gov to determine potential eligibility for health care coverage? ☐ Yes ☐ No	If **yes**, referral date: / /

Información del paciente			
Apellido(s):	Primer nombre:	Inicial del 2.º nombre:	
Fecha de nacimiento: / /	Sexo: ☐ Mujer ☐ Hombre		
Dirección:		N.º de apartamento:	
Ciudad:	Estado:	Código postal:	Condado:
Teléfono:		Correo electrónico:	
Otro(s) nombre(s) usado(s): (*Apellido*)		(*Nombre*)	
Información de un contacto alternativo *(en caso de que no podamos comunicarnos con usted)*			
Nombre:		Relación con usted:	
Dirección:		N.º de apartamento:	
Ciudad:	Estado:	Código postal:	Teléfono:

Información de elegibilidad

¿Tiene usted seguro médico o Medicaid? ☐ Sí ☐ No

Si la respuesta es **Sí**, ¿es lo siguiente VERDADERO?

Mi plan de seguro médico no cubre completamente servicios de pruebas para la detección de cáncer de mama y de cuello uterino, como mamografías y/o análisis de Papanicolaou. ☐ Sí ☐ No

Mis costos pagados de mi propio bolsillo para servicios de diagnóstico representan una dificultad económica ☐ Sí ☐ No

¿A cuánto ascienden los ingresos mensuales brutos de su grupo familiar? *(Este es el total de los ingresos de todos los integrantes del grupo familiar antes de descontarse los impuestos)*:

¿Cuántas personas viven en su grupo familiar *(incluido usted)*?:

Información demográfica (*recopilamos esta información para brindarle un mejor servicio)*

Origen latino o hispano:	☐ Sí	☐ No	☐ No sabe	☐ Prefiere no contestar
Origen judío ashkenazi:	☐ Sí	☐ No	☐ No sabe	☐ Prefiere no contestar

Preferencia de idioma:

Raza: *(elija una o más opciones)*	☐ Indígena estadounidense o nativo de Alaska	☐ Blanco
	☐ Asiático	☐ Otro:
	☐ Negro o afroestadounidense	☐ No sabe
	☐ Nativo de Hawái o de las Islas del Pacífico	☐ Prefiere no contestar
Si eligió más de una raza, ¿cuál considera que es su raza principal?	☐ Indígena estadounidense o nativo de Alaska	☐ No tengo identidad de raza principal
	☐ Asiático	☐ Otro:
	☐ Negro o afroestadounidense	☐ No sabe
	☐ Nativo de Hawái o de las Islas del Pacífico	☐ Prefiere no contestar
	☐ Blanco	

Discapacidad *(marque todas las que correspondan; opcional):*	☐ Física/movilidad ☐ Intelectual/cognitiva	☐ Audición Otro:	☐ Vista

Consentimiento del cliente

Al inscribirse en el programa de ScreenWise, acepto las condiciones incluidas en este formulario:

- ScreenWise puede pagar las pruebas para la detección del cáncer de mama y de cuello uterino y las pruebas de diagnóstico, y puede pagar los servicios de detección relacionados con la enfermedad cardíaca y el accidente cerebrovascular (embolia), si mi proveedor está inscrito para ofrecer estos servicios.
- ScreenWise no pagará el tratamiento para el cáncer y es posible que yo deba pagar las pruebas y el tratamiento que ScreenWise no cubre.
- Ser elegible para los servicios de diagnóstico y detección del cáncer de mama y de cuello uterino no garantiza que también recibiré servicios de detección relacionados con la enfermedad cardíaca ni con el accidente cerebrovascular.
- No tengo Medicaid, Medicare ni otro seguro médico que pueda pagar por estas pruebas de detección.
- ScreenWise tiene normas sobre quién puede inscribirse en el programa. Toda la información que he proporcionado a la clínica es verdadera, a mi leal saber y entender. Si proporciono a la clínica información falsa, es posible que no obtenga estas pruebas y deba pagar cualquier prueba que ya haya sido realizada.
- ScreenWise, mis proveedores de atención médica, las clínicas y/o los hospitales pueden compartir información entre sí sobre mi atención médica y cualquier atención médica relacionada que yo reciba mediante ScreenWise; y pueden organizar mi atención y mi participación en asesoramiento de salud, programas de estilo de vida basados en la evidencia y con la línea telefónica para dejar de fumar de Oregon (Oregon Tobacco Quit Line).
- Mi información no se compartirá con nadie, a excepción de los proveedores contratados por ScreenWise y sus entidades financiadoras. No se incluirá mi nombre en ningún informe que se publique.
- Comprendo que tengo el derecho de retirarme del programa ScreenWise mediante un comunicado por escrito a mi proveedor de atención médica. Comprendo que ScreenWise conservará toda la información que haya compartido antes de que me retire del programa.
- Comprendo que puedo recibir cartas por correo postal, por parte de mi médico para recordarme cuándo es el momento de regresar a la clínica para que se me realicen pruebas de detección o de otro tipo.
- Este formulario de inscripción vence a un año de la fecha en que lo firmo, lo que significa que deberé volver a inscribirme al cabo de 12 meses para poder seguir recibiendo los servicios.

Firma del cliente:	Fecha:
Nombre del cliente *(letra de molde)*:	
Firma del intérprete *(de utilizarse)*:	Fecha:

Print **Reset**

Oregon Health Authority
PUBLIC HEALTH DIVISION
ScreenWise Program

Screening Form

Reset 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 *(report results if known)* ☐ 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 *(report results below if known)* ☐ 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 *(report results if known)* ☐ 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? *(continued)*	☐ 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

Pap

Adequacy	☐ Satisfactory ☐ Specimen not processed ☐ Unsatisfactory ☐ Unknown
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: _____

HPV test

HPV (high risk) test done?	☐ Yes ☐ No ☐ Unknown
Location sent to:	
Result:	☐ Positive ☐ Negative
Date:	/ /

Breast

Mammogram

Mammogram Date:	/ /
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

NEXT STEPS:

Cervical		Breast	
Follow-up Recommendation	☐ Follow routine screening ☐ Short-term follow-up _____ Months ☐ Repeat Pap test ☐ Additional diagnostic procedures *(select one)* ☐ 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 *(select one)* ☐ CBE by consult ☐ Diagnostic mammogram ☐ Ultrasound ☐ Surgical consult ☐ Biopsy ☐ FNA/Cyst aspiration

Print Form

Oregon Health Authority
PUBLIC HEALTH DIVISION
ScreenWise Program

Abnormal Follow-Up Form

Reset Form

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

Enrolling Agency or Site: _____ Patient ID: _____

Additional Diagnostic Procedures

Cervical		Breast	
Date of 1st Procedure: / /		Date of 1st Procedure: / /	
Procedure Location:		Procedure Location:	
Type	☐ Colposcopy without biopsy ☐ Colpo with biopsy and/or ECC ☐ LEEP ☐ Cold Knife Cone (CKC) ☐ Endocervical curretage (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 2nd Procedure: / /		Date of 2nd 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 curretage (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 ***continued on page 2→***	Follow-up Recommendation	☐ Follow routine screening ☐ Short-term follow-up _____ months ☐ Additional diagnostic procedures ☐ CBE by consult ***continued on page 2→***

Abnormal Follow-Up Form

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

Follow-up Recommendation *(continued)*	☐ 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 *(continued)*	☐ 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

Print Form