Florida Breast and Cervical Cancer Early Detection Program

Patient Reporting Form (PRF)

☐ **Enrollee into FBCCEDP**

☐ **Patient Navigation Only**

Lead Region: _____ **Date Enrolled:** _____

RC Initials: _____ **RC Date Reviewed:** _____

GENERAL INFORMATION

1. Basic Demographics

Full Name: _____
Last *First* *Middle Initial*

Date of Birth: ____/____/____ **SSN:** _____ **Telephone:** _____

Mailing Address: _____

_____
City *County* *Zip Code*

Hispanic? Yes ☐ No ☐

Race: (✓ all that apply)

☐ White	☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American	☐ American Indian or Alaska Native
☐ Asian	☐ Unknown

Primary Language: _____

2. Personal Health Information

Height (inches): _____ **Weight (pounds):** _____

Has medical personnel ever told the client she was: (✓ all that apply)

☐ Pre-diabetic	☐ High blood pressure
☐ Diabetic	☐ High blood cholesterol

Referred to Services: Yes ☐ No ☐

Tobacco Use *(including vaping, e-cigarettes or similar products):* Daily ☐ Some Days ☐ Not at all ☐ Declined to answer ☐

Referred to Quitline: Yes ☐ No, not referred ☐ Declined referral ☐

3. Screening, Undocumented and How Learned of Program

Screening Status: Initial ☐ Rescreen ☐ Short-term Follow-up ☐

Undocumented: Yes ☐ No ☐

How did client learn about the program?

☐ ACS	☐ Billboards	☐ Brochures
☐ Bus wraps/bench/placards	☐ CHD	☐ Community
☐ Educational Session	☐ Family/Friend	☐ FQHC Name:
☐ In-reach	☐ Internet	☐ Medical Office
☐ Newspaper	☐ Outreach	☐ Postcard
☐ Radio	☐ Social Media	☐ Television
Other:		

Name: _____ DOB: ____/____/____ Lead Region: _____

BREAST

4. Breast Risk Information and History *(Yes/No answers should be chosen if risk assessed and determined by provider)*

High Risk for Breast Cancer: Yes ☐ No ☐ Not Assessed/Unknown ☐

Symptoms: Yes ☐ No ☐

Has client ever had: breast cancer? Yes ☐ No ☐

a previous mammogram? Yes ☐ No ☐

Date of previous mammogram: ____/____/____

5. Clinical Breast Exam

CBE Result: Not performed ☐ Normal/ Benign ☐ Abnormality Suspicious for Cancer ☐ →

CBE Provider #: _____

CBE Screening Date: ____/____/____

CBE Paid by FBCCEDP: ☐ Yes ☐ No

Additional Breast Procedures for CBE

☐ Additional procedures needed or planned

☐ Additional procedures not needed or planned

6. Mammogram

Mam Provider #: _____

Mam Screening Date: ____/____/____

Mam Paid by FBCCEDP: ☐ Yes ☐ No

Indication for Mammogram

☐ Screening

☐ Diagnostic

☐ Non-program mammogram.
Referred in for diagnostic evaluation
Breast Diagnostic Referral Date: ____/____/____

☐ No mammogram

☐ No breast service

☐ Unknown

Mammogram Result

☐ Negative (BI-RADS 1)

☐ Benign Finding (BI-RADS 2)

☐ Probably Benign/STFU suggested (BI-RADS 3)

☐ Unsatisfactory

☐ Result Pending

☐ Result unknown, presumed abnormal, mam from non-funded source

☐ Suspicious Abnormality (BI-RADS 4)

☐ Highly Suggestive of Malignancy (BI-RADS 5)

☐ Need evaluation or film comparison (BI-RADS 0)

Additional Procedures for Mammogram

☐ Additional procedures needed or planned

☐ Additional procedures not needed or planned

☐ Need or plan for additional procedures not yet determined.

Next mammogram date: ____/____/____

6. Screening MRI (high-risk only)

MRI Pre-Authorization Date: _____

Central Office Nurse: _____

Screening MRI Provider#: _____

Screening MRI Date: ____/____/____

Screening MRI Paid by FBCCEDP: ☐ Yes ☐ No

Screening MRI Result

☐ Negative (BI-RADS 1)

☐ Benign Finding (BI-RADS 2)

☐ Probably Benign indicated (BI-RADS 3)

☐ Unsatisfactory

☐ Result Pending

☐ Not done

☐ Suspicious (BI-RADS 4)

☐ Highly Suggestive of Malignancy (BI-RADS 5)

☐ Known Malignancy (BI-RADS 6)

☐ Need Additional Imaging Evaluation (BI-RADS 0)

Additional Procedures for Screening MRI

☐ Additional procedures needed or planned

☐ Additional procedures not needed or planned

☐ Need or plan for additional procedures not yet determined.

Name: _____ DOB: ___/___/___ Lead Region: _____

8. Additional Breast Procedures

Breast Imaging Procedures	Date	Paid Yes	Paid No	Provider Number
☐ Additional Mammographic Views	_____	☐	☐	_____
☐ Ultrasound	_____	☐	☐	_____
☐ Film Comparison	_____	☐	☐	_____
MRI Pre-Authorization Date:	_____	**Central Office Nurse:**		_____
☐ **Magnetic Resonance Imaging**	_____	☐	☐	_____

Check if additional page 3, Section 7. Additional Breast Procedures, is needed to document more than one imaging procedure: ☐

Final Imaging Outcome

- ☐ Negative (BI-RADS 1)
- ☐ Benign Finding (BI-RADS 2)
- ☐ Probably Benign/STFU suggested (BI-RADS 3)
- ☐ Suspicious abnormality (BI-RADS 4)
- ☐ Highly suspicious of malignancy (BI-RADS 5)
- ☐ Known Malignancy (BI-RADS 6)
- ☐ Results pending

Final Imaging Date: _____

Breast Diagnostic Procedures	Date	Paid Yes	Paid No	Provider Number
☐ Repeat Breast Exam/☐ Surgical Consultation	_____	☐	☐	_____
☐ Repeat Breast Exam/☐ Surgical Consultation	_____	☐	☐	_____
☐ Biopsy	_____	☐	☐	_____
☐ Repeat Biopsy *(comment required)*	_____	☐	☐	_____
☐ Fine Needle/Cyst Aspiration	_____	☐	☐	_____

Name: _____ DOB: ___/___/___ Lead Region : _____

9. Breast Final Diagnosis

Status of Breast Final Diagnosis

- ☐ Work-up complete
- ☐ Work-up pending

☐ Lost to follow-up - not otherwise specified	☐ Refused - not otherwise specified
☐ Lost to follow-up - deceased	☐ Refused - ineligible due to income or insurance
☐ Lost to follow-up - moved	

If status of final diagnosis is lost to follow-up or refused, complete comments section below.

Final Breast Diagnosis	Left	Right
☐ Breast Cancer Not Diagnosed		
☐ Carcinoma In Situ, Other	☐	☐
☐ Invasive Breast Cancer	☐	☐
☐ Lobular Carcinoma In Situ (LCIS) (Stage 0)	☐	☐
☐ Ductal Carcinoma In Situ (DCIS) (Stage 0)	☐	☐
☐ Atypical Ductal Hyperplasia (ADH)	☐	☐

Final Diagnosis Date: _____

Diagnosis Facility: _____
(include Provider Number)

10. Breast Cancer Treatment Status

- ☐ Treatment started
- ☐ Treatment pending

☐ Lost to follow-up - not otherwise specified	☐ Refused - not otherwise specified
☐ Lost to follow-up - deceased	☐ Refused - ineligible due to income or insurance
☐ Lost to follow-up - moved	

If status of final diagnosis is lost to follow-up or refused, complete comments section below.

Treatment Start Date: _____

Treatment Facility: _____

Comments

CENTRAL OFFICE USE ONLY – MEDICAID FOR BREAST CANCER				COMMENTS:
	Yes	No		
REFERRED TO MEDICAID FOR TREATMENT?	☐	☐	MEDICAID REFERRAL DATE: _____	
	Yes	No		
PATIENT ENROLLED?	☐	☐	MEDICAID APPROVAL DATE: _____	

Name: _____ DOB: ___/___/___ Lead Region : _____

CERVICAL

11. Cervical Cancer Risk Information and History (Yes/No answers should be chosen if risk assessed and determined by provider)

	Yes	No	Not Assessed/Unknown		Yes	No
Risk for Cervical Cancer:	☐	☐	☐	**Previous Dx'd Cervical Cancer ?**	☐	☐

	Yes	No	Unknown	
Previous Pap Test?	☐	☐	☐	**Date of Previous Pap?** _____

12. Pap

Indication for Pap

- ☐ Screening
- ☐ Surveillance
- ☐ Non-program Pap. Referred in for diagnostic evaluation
  - **Cervical Diagnostic Referral Date:** ___/___/___
- ☐ No Pap
- ☐ No cervical service
- ☐ Pap after primary HPV+
- ☐ Unknown

Pap Provider #: _____

Pap Screening Date: ___/___/___

Pap Paid by FBCCEDP: ☐ **Yes** ☐ **No**

Specimen Type: ☐ Conventional Smear ☐ Liquid Based

Specimen Adequacy: ☐ Satisfactory ☐ Unsatisfactory

Pap Result

- ☐ Negative for intraepithelial lesion or malignancy
- ☐ Infection/Inflammation/Reactive Changes
- ☐ Atypical squamous cells of undetermined significance (ASC-US)
- ☐ Low Grade SIL (including HPV changes)
- ☐ Other _____
- ☐ Unsatisfactory
- ☐ Result Pending

- ☐ Atypical squamous cells cannot exclude HSIL (ASC-H)
- ☐ High Grade SIL
- ☐ Squamous Cell Carcinoma
- ☐ Atypical Glandular Cells
- ☐ Adenocarcinoma In Situ (AIS)
- ☐ Adenocarcinoma
- ☐ Result Unknown, presumed abnormal, Pap test from non-program funded source

Diagnostic Work-up Planned for Cervical Dysplasia or Cancer:

- ☐ Diagnostic work-up planned on basis of abnormal Pap test or pelvic exam
- ☐ Diagnostic work-up not planned
- ☐ Diagnostic work-up plan not yet determined

Next Pap date: ___/___/___

13. HPV

Indication for HPV

- ☐ Co-Test/Screening
- ☐ Reflex (follow-up test after screening Pap)
- ☐ Test not done
- ☐ Unknown

HPV Provider #: _____

HPV Screening Date: ___/___/___

HPV Paid by FBCCEDP: ☐ **Yes** ☐ **No**

HPV Result

- ☐ Positive with genotyping not done/Unknown
- ☐ Negative
- ☐ Positive with positive genotyping (types 16 or 18)
- ☐ Positive with negative genotyping (positive HPV, but not types 16 or 18)
- ☐ Unknown

Name: _____ DOB: ___/___/___ Lead Region : _____

14. CERVICAL DIAGNOSTIC PROCEDURES

Cervical Diagnostic Procedures	Date	Paid Yes	Paid No	Provider Number
☐ Colposcopy without biopsy		☐	☐	
☐ Colposcopy with biopsy and/or ECC		☐	☐	
☐ Other cervical procedures performed		☐	☐	
Please specify:				
☐ ECC alone		☐	☐	

LEEP or Cold Knife Cone Pre-Authorization Date:		Central Office Nurse: Yes	No	
☐ Diagnostic Cold Knife Cone (CKC)		☐	☐	
☐ Diagnostic LEEP		☐	☐	

15. CERVICAL FINAL DIAGNOSIS

Status of Cervical Final Diagnosis

☐ Work-up complete
☐ Work-up pending

☐ Lost to follow-up - not otherwise specified	☐ Refused - not otherwise specified
☐ Lost to follow-up - deceased	☐ Refused - ineligible due to income or insurance
☐ Lost to follow-up - moved	

If status of final diagnosis is lost to follow-up or refused, complete comments section below.

Final Cervical Diagnosis

☐ Normal/Benign reaction/inflammation
☐ HPV/Condylomata/Atypia
☐ CIN 1/mild dysplasia (biopsy diagnosis)
☐ CIN 2/moderate dysplasia (biopsy diagnosis)
☐ CIN 3/severe dysplasia/Carcinoma in situ (Stage 0) or Adenocarcinoma in situ of the cervix (AIS) (biopsy diagnosis)
☐ Invasive cervical carcinoma (biopsy diagnosis)
☐ Other cancer diagnosis (only if patient has no cervix due to cervical cancer): _____
☐ Low grade SIL (biopsy diagnosis)
☐ High grade SIL (biopsy diagnosis)

Final Diagnosis Date: _____ **Diagnosis Facility:** _____
(include Provider Number)

16. Cervical Cancer Treatment Status

☐ Treatment started
☐ Treatment pending

☐ Lost to follow-up - not otherwise specified	☐ Refused - not otherwise specified
☐ Lost to follow-up - deceased	☐ Refused - ineligible due to income or insurance
☐ Lost to follow-up - moved	

If status of final diagnosis is lost to follow-up or refused, complete comments below.

Treatment Start Date: _____ **Treatment Facility:** _____

Comments

CENTRAL OFFICE USE ONLY – MEDICAID FOR CERVICAL CANCER				COMMENTS:
	Yes	No		
REFERRED TO MEDICAID FOR TREATMENT?	☐	☐	MEDICAID REFERRAL DATE: _____	
	Yes	No		
PATIENT ENROLLED?	☐	☐	MEDICAID APPROVAL DATE: _____	