# Take Charge! Breast and Cervical Cancer Screening Form
# ODH Form No.274A

Part 1: PATIENT DEMOGRAPHIC INFORMATION (*Write Chart# per your office instructions and write the name of your facility. Ask client for correct spelling of first and last name. Also note client's middle and maiden names, if applicable*)

| | |
|---|---|
| Chart ID#_____ | Facility Name: _____ |
| (*Write the four digit number that is assigned to your facility*) | (*If client does not have a Social Security Number write "999-99-999"*) |

| | | | | |
|---|---|---|---|---|
| Facility Site Number: _____ | Social Security Number: _____-_____-_____ | | | Age: _____ |
| Last Name: _____ | First Name:_____ | MI: _____ | Maiden: _____ | |
| DOB: _____/_____/_____ | Daytime phone # :( _____ ) _____ | | | |
| Cell Phone#: ( _____ ) _____ | Email: _____ | | | |
| Address: _____ | City: _____ | State: _____ | Zip: _____ | County: _____ |

(*Mark one or more of client's self-reported responses for Race and the client's self-reported response for Ethnicity*)

| | | | | |
|---|---|---|---|---|
| Race | ☐ White | ☐ Black or African American | ☐ American Indian or Alaska Native | |
| | ☐ Native Hawaiian or other Pacific Islander | | ☐ Asian | ☐ Unknown |
| Ethnicity | ☐ Hispanic or Latino | ☐ Non-Hispanic or Non-Latino | ☐ Unknown | |

Part 2: REFERRAL SOURCE (*Select one option below as the client's source of referral to the Take Charge Program*)

| | | | | | |
|---|---|---|---|---|---|
| ☐ Community Organization | ☐ Health Department | ☐ Family/Friend | ☐ Health Fair | ☐ Worksite | ☐ Provider |
| ☐ Flyer/Brochure/Poster | ☐ Presentation | ☐ Media | ☐ Self | ☐ Recall/Reminder | |

Part 3: RISK FOR BREAST CANCER:
(*Genetic mutation, i.e. BRCA gene; mother, sister or daughter with breast cancer; radiation treatments to chest between ages 10–30 years; 20% or more lifetime risk for breast cancer; past history breast cancer*). *If yes consider referral for screening MRI.*

☐ Yes ☐ No ☐ Not Assessed/Unknown

Part 4: BREAST CANCER SCREENING INFORMATION (*Mark client's self-reported breast symptoms*)

Client Reports Breast Symptoms? ☐ Yes ( ☐ *Lump* ☐ *Nipple Discharge* ☐ *Pain* ☐ *Skin Changes* ) ☐ No

| | | |
|---|---|---|
| Prior Mammogram?: ☐ Yes ☐ No ☐ Unknown | Facility Name/Location: _____ | Date: _____/_____/_____ |

Part 5A: INDICATION FOR INITIAL MAMMOGRAM (*Select one option as the reason for the initial mammogram*)

| | |
|---|---|
| ☐ Routine Screening Mammogram | ☐ Cervical Record Only - No Breast Service |
| ☐ Diagnostic Referral | ☐ Refused |
| ☐ Non Program Mammogram, CBE Only, Referred in for Diagnostic Evaluation | ☐ Unknown |
| ☐ No Mammogram, Direct to Diagnostics for Short Term Follow Up | |

Part 5B: CLINICIAL BREAST EXAM (CBE) INFORMATION

Facility name: _____

Date CBE Performed: _____/_____/_____

CBE Paid by Take Charge! Program?
☐ Yes ☐ No ☐ Unknown

Findings of CBE: (*Bold results require Work Up and completion of Form 274C*)

☐ Normal/Benign Finding (Schedule for Routine CBE in 1 year)
Requires recent negative imaging (mammo +/-US)

- ☐ *Asymmetry by Palpation +/- Pain*
- ☐ *Mass Poorly Defined and Soft or Cyst on Imaging*
- ☐ *Low Volume Discharge or Heme Negative Discharge*
- ☐ *Persistent Regional Pain*

☐ **Abnormality – Suspicious for Cancer - *Select symptoms below .* (*Diagnostic Evaluation Needed*)**

- ☐ *Discrete Palpable Mass (firmer than superball)*
- ☐ *Nipple Scaliness*
- ☐ *Bloody Discharge or High Volume Discharge*
- ☐ *Skin Dimpling or Retraction*

☐ CBE Not Performed

Clinical Comments (*Handwritten notes are not entered into database*):

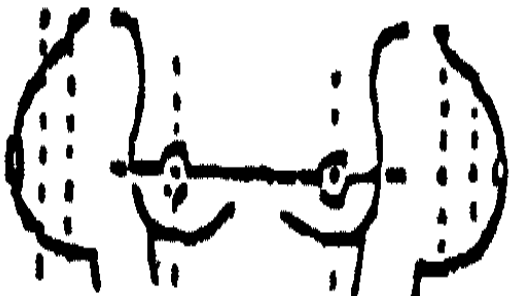

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Chart ID#_____ (*Write Chart# per your office instructions*)

5C: BREAST IMAGING (*Mark the reason client is referred for Mammogram and/or MRI*)

| MAMMOGRAM INFORMATION | | MRI INFORAMTION |
|---|---|---|
| Referred for: ☐ Screening Mammogram ☐ Diagnostic Mammogram | | Referred for Screening MRI: ☐ Yes ☐ No |
| Screening Mammo Referral Date: _____/_____/_____ | | Screening MRI Referral Date: _____/_____/_____ |
| Paid by Take Charge! Program? ☐ Yes ☐ No ☐ Unknown | | Paid by Take Charge! Program? ☐ Yes ☐ No ☐ Unknown |
| Facility Name: _____ | | Facility Name: _____ |
| Date Performed: _____/_____/_____ | | Date Performed: _____/_____/_____ |
| Date Provider Received Results: _____/_____/_____ | | Date Provider Received Results: _____/_____/_____ |
| Date Client Notified by Provider: _____/_____/_____ | | Date Client Notified by Provider: _____/_____/_____ |
| Breast Diagnostic Referral Date: _____/_____/_____ | | |
| Results of Mammogram (*Bold results require Work-up and completion of Form 274C*) | | Results of Screening MRI (*Bold results require Work-up and completion of Form 274C*) |
| ☐ **BI-RADS® 0** | ***Need Evaluation :-Additional Imaging and/or Film Comparison*** | ☐ **Incomplete – Need Additional Imaging Evaluation** |
| ☐ BI-RADS® 1 | *Negative* | ☐ Negative |
| ☐ BI-RADS® 2 | *Benign Finding* | ☐ Benign Finding |
| ☐ BI-RADS® 3 | *Probably Benign – Repeat Diagnostic Mammogram in 6 months.* | ☐ Probably Benign |
| | | ☐ **Suspicious** |
| ☐ **BI-RADS® 4** | ***Suspicious Abnormality – Consider Biopsy*** | ☐ **Highly Suggestive of Malignancy** |
| ☐ **BI-RADS® 5** | ***Highly Suggestive of Malignancy Appropriate Action Should Be Taken*** | ☐ **Known Malignancy (equivalent to BIRADS 6)** |
| ☐ Unsatisfactory | | ☐ Result Pending |
| ☐ Result Pending | | ☐ Not Done |
| ☐ **Result Unknown** | ***Presumed Abnormal, Mammogram from Non Take Charge! facility*** | |

ADDITIONAL PROCEDURES NEEDED TO COMPLETE BREAST CYCLE:

| *If Work-up is Planned – mark type of work up needed. Complete Form 274 C to show client's final disposition* | *If Work-up is Not Planned, mark the appropriate response. If short-term follow up is needed- list the number of months recommended.* |
|---|---|
| ☐ Yes - Needed or Planned - *(mark type of work up needed below)* | ☐ No, Not Needed |
| ☐ CBE by Consult | ☐ Follow Routine Screening (1 year) |
| ☐ Repeat Mammogram Immediately | ☐ Follow Up in 2 years |
| ☐ Additional Mam Views | ☐ Short-term Follow Up: _____ months |
| ☐ Film Comparison | ☐ Not Yet Determined |
| ☐ Ultrasound | ☐ Unknown |
| ☐ Biopsy | |
| ☐ FNA | |
| ☐ Surgical Consultation | |
| ☐ Obtain Definitive Diagnosis | |
| ☐ Other, List:_____ | |

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Chart ID#:_____ (*Mark chart# per your office instructions*)

**Part 6: CERVICAL CANCER SCREENING INFORMATION**

Previous Pap test? ☐ Yes ☐ No ☐ Unknown Facility:_____ Date: _____/_____/_____

Hysterectomy? ☐ Yes ☐ No Date: _____/_____/_____ Cervical Cancer?: ☐ Yes ☐ No Date: _____/_____/_____

Past Abnormal Pap? ☐ Yes ☐ No Year: _____ Type: _____ Treatment Method: _____

**Part 7A: INDICATION FOR PAP TEST**

| | | |
|---|---|---|
| ☐ Screening ☐ Surveillance | ☐ No Pap | ☐ No Cervical Service |
| ☐ Non-program Pap, Referred in for Diagnostic Evaluation | ☐ Pap after Primary HPV+ | ☐ Unknown |

**Part 7B: RISK FOR CERVICAL CANCER** (*HPV, tobacco use, HIV, long-term use of birth control, 3 or more childbirths*)

☐ Yes ☐ No ☐ Not Assessed/Unknown

**Part 7C: PELVIC INFORMATION**

Facility Name: _____

Type of exam: ☐ Pelvic ☐ Visual Vaginal/Perineal

Date of exam: _____/_____/_____

Paid by Take Charge! Program? ☐ Yes ☐ No ☐ Unknown

Results of Pelvic Exam

☐ Abnormal Pelvic (*suspicious for cervical cancer* ☐ *yes* ☐ *no*)

☐ Normal

☐ Not Done–Normal PE in past 12 months (*attach records*)

☐ Not Done – Other/Unknown Reason

☐ Not Indicated/Not Needed

☐ Refused

Clinical Comments: (*Notes are not entered into database*)

**Part 7D: PAP TEST** (*Bold results require Work-up and completion of Form 274C*)

Facility Name: _____

Date Pap Test Performed: _____/_____/_____

Paid by Take Charge! Program? ☐ Yes ☐ No ☐ Unknown

Date Provider Received Result: _____/_____/_____

Date Client Notified: _____/_____/_____

Specimen Adequacy: ☐ Satisfactory ☐ **Unsatisfactory** ☐ **Unknown**

Results of Pap Test:

| | |
|---|---|
| ☐ **Adenocarcinoma** | ☐ **ASC-US** |
| ☐ **AGC (Atypical Glandular Cells)** Changes | ☐ **ASC-H** |
| ☐ **AIS (Adenocarcinoma In Situ)** | ☐ **HSIL** |
| ☐ **Squamous Cell Carcinoma** | ☐ Result Pending |
| ☐ **LSIL includes HPV, Mild Dysplasia, CIN1** | ☐ Unsatisfactory |
| ☐ Negative for Intraepithelial Lesion/Malignancy | ☐ Other (*specify*) |
| ☐ Infection/Inflammation/Reactive | |

☐ **Result Unknown -** ***Presumed Abnormal -Pap Test from Non Take Charge source***

**Part 7E: INDICATION FOR HPV TEST**

☐ Screening/Co-test

☐ Reflex

☐ Test Not Done

☐ Unknown

**7F: HPV TEST INFORMATION**

HPV Test Performed: ☐ Yes ☐ No

Date of HPV Test:_____/_____/_____

Paid by Take Charge! Program? ☐ Yes ☐ No

HPV Test Result: ☐ **Positive** - Genotype Not Done/Unknown ☐ Negative

☐ **Positive** - Positive Genotype ☐ Unknown

☐ **Positive** - Negative Genotype

Date Provider Received Results: _____/_____/_____ Date Client Notified: ___/___/___

**ADDITIONAL PROCEDURES NEEDED TO COMPLETE CERVICAL CYCLE:** (*If work up is planned – mark type of work up needed*).

☐ Yes - Needed or Planned (*mark type of work-up below*)

| | | | |
|---|---|---|---|
| ☐ Cold Knife Cone (CKC) | ☐ Endocervical Curettage (ECC) | ☐ LEEP | ☐ HPV Test |
| ☐ Colposcopy with Biopsy | ☐ Pelvic Ultrasound | ☐ Hysterectomy | |
| ☐ Colposcopy w/o Biopsy | ☐ Gynecological Consultation | ☐ Repeat Pap Test Immediately | |
| ☐ Other Biopsy | ☐ Obtain Definitive Treatment | | |

☐ No - Not needed - ☐ 4 Month Short-Term Follow-up ☐ 6 Month Short-Term Follow-up ☐ Follow Routine Screening

**Part 8: TOBACCO USE INFORMATION:** (*Ask client following set of questions and mark their responses*)

| | | | | |
|---|---|---|---|---|
| Have you smoked at least 100 cigarettes in your entire life (5 packs=100 cigarettes)? | | ☐ Yes | ☐ No | ☐ Don't know/Not sure ☐ Refused |
| Do you now smoke cigarettes? | ☐ Every day ☐ Some days | ☐ Not at all | | ☐ Don't know/Not sure ☐ Refused |
| Do you currently use any other type of tobacco such as cigars, pipes, or smokeless tobacco? | ☐ Every day ☐ Some days | ☐ Not at all | | ☐ Don't know/Not sure ☐ Refused |
| Do you currently use e-cigarettes or any other type of vapor products? | ☐ Every day ☐ Some days | ☐ Not at all | | ☐ Don't know/Not sure ☐ Refused |

Do you live with anyone who uses tobacco? ☐ Yes ☐ No

Was a fax referral for Quitline (Tobacco cessation) offered to the patient? ☐ Yes ☐ No If no, why not? _____

Was the fax referral accepted by the patient? ☐ Yes ☐ No If no, why not? _____

**Clinician completing the screening must sign and date after the form is completed.**

Examiner's Signature: Date: _____/_____/_____