

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	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaska Native
	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown
Ethnicity	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino <input type="checkbox"/> Unknown		

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

<input type="checkbox"/> Community Organization	<input type="checkbox"/> Health Department	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Health Fair	<input type="checkbox"/> Worksite	<input type="checkbox"/> Provider
<input type="checkbox"/> Flyer/Brochure/Poster	<input type="checkbox"/> Presentation	<input type="checkbox"/> Media	<input type="checkbox"/> Self	<input type="checkbox"/> 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? <input type="checkbox"/> Yes (<input type="checkbox"/> Lump <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Pain <input type="checkbox"/> Skin Changes)	<input type="checkbox"/> No
Prior Mammogram?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility Name/Location: _____ Date: _____ / _____ / _____

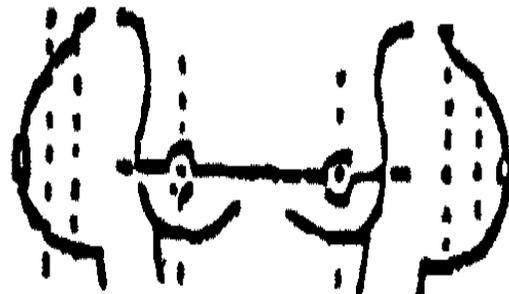
Part 5A: INDICATION FOR INITIAL MAMMOGRAM (Select one option as the reason for the initial mammogram)

<input type="checkbox"/> Routine Screening Mammogram	<input type="checkbox"/> Cervical Record Only - No Breast Service
<input type="checkbox"/> Diagnostic Referral	<input type="checkbox"/> Refused
<input type="checkbox"/> Non Program Mammogram, CBE Only, Referred in for Diagnostic Evaluation	<input type="checkbox"/> Unknown
<input type="checkbox"/> No Mammogram, Direct to Diagnostics for Short Term Follow Up	

Part 5B: CLINICAL BREAST EXAM (CBE) INFORMATION

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

Facility name: _____
Date CBE Performed: _____ / _____ / _____
CBE Paid by Take Charge! Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Findings of CBE: (Bold results require Work Up and completion of Form 274C)
<input type="checkbox"/> Normal/Benign Finding (Schedule for Routine CBE in 1 year) Requires recent negative imaging (mammo +/-US)
<input type="checkbox"/> Asymmetry by Palpation +/- Pain
<input type="checkbox"/> Mass Poorly Defined and Soft or Cyst on Imaging
<input type="checkbox"/> Low Volume Discharge or Heme Negative Discharge
<input type="checkbox"/> Persistent Regional Pain
<input type="checkbox"/> Abnormality – Suspicious for Cancer - Select symptoms below . (Diagnostic Evaluation Needed)
<input type="checkbox"/> Discrete Palpable Mass (firmer than superball)
<input type="checkbox"/> Nipple Scalliness
<input type="checkbox"/> Bloody Discharge or High Volume Discharge
<input type="checkbox"/> Skin Dimpling or Retraction
<input type="checkbox"/> CBE Not Performed



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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 INFORMATION
Referred for: <input type="checkbox"/> Screening Mammogram <input type="checkbox"/> Diagnostic Mammogram	Referred for Screening MRI: <input type="checkbox"/> Yes <input type="checkbox"/> No
Screening Mammo Referral Date: _____/_____/_____	Screening MRI Referral Date: _____/_____/_____
Paid by Take Charge! Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Paid by Take Charge! Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 (<i>Bold results require Work-up and completion of Form 274C</i>)	Results of Screening MRI (<i>Bold results require Work-up and completion of Form 274C</i>)
<input type="checkbox"/> BI-RADS® 0 <i>Need Evaluation :-Additional Imaging and/or Film Comparison</i>	<input type="checkbox"/> Incomplete – Need Additional Imaging Evaluation
<input type="checkbox"/> BI-RADS® 1 <i>Negative</i>	<input type="checkbox"/> Negative
<input type="checkbox"/> BI-RADS® 2 <i>Benign Finding</i>	<input type="checkbox"/> Benign Finding
<input type="checkbox"/> BI-RADS® 3 <i>Probably Benign – Repeat Diagnostic Mammogram in 6 months.</i>	<input type="checkbox"/> Probably Benign
<input type="checkbox"/> BI-RADS® 4 <i>Suspicious Abnormality – Consider Biopsy</i>	<input type="checkbox"/> Suspicious
<input type="checkbox"/> BI-RADS® 5 <i>Highly Suggestive of Malignancy Appropriate Action Should Be Taken</i>	<input type="checkbox"/> Highly Suggestive of Malignancy
<input type="checkbox"/> Unsatisfactory	<input type="checkbox"/> Known Malignancy (equivalent to BIRADS 6)
<input type="checkbox"/> Result Pending	<input type="checkbox"/> Result Pending
<input type="checkbox"/> Result Unknown <i>Presumed Abnormal, Mammogram from Non Take Charge! facility</i>	<input type="checkbox"/> Not Done
ADDITIONAL PROCEDURES NEEDED TO COMPLETE BREAST CYCLE:	
<i>If Work-up is Planned – mark type of work up needed. Complete Form 274 C to show client's final disposition</i>	<i>If Work-up is Not Planned, mark the appropriate response. If short-term follow up is needed- list the number of months recommended.</i>
<input type="checkbox"/> Yes - Needed or Planned - (mark type of work up needed below)	<input type="checkbox"/> No, Not Needed
<input type="checkbox"/> CBE by Consult	<input type="checkbox"/> Follow Routine Screening (1 year)
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> Follow Up in 2 years
<input type="checkbox"/> Additional Mam Views	<input type="checkbox"/> Short-term Follow Up: _____ months
<input type="checkbox"/> Film Comparison	<input type="checkbox"/> Not Yet Determined
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Unknown
<input type="checkbox"/> Biopsy	
<input type="checkbox"/> FNA	
<input type="checkbox"/> Surgical Consultation	
<input type="checkbox"/> Obtain Definitive Diagnosis	
<input type="checkbox"/> Other, List: _____	

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Chart ID#: _____ (Mark chart# per your office instructions)	
Part 6: CERVICAL CANCER SCREENING INFORMATION	
Previous Pap test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Facility: _____ Date: ____/____/____	
Hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____ Cervical Cancer?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____	
Past Abnormal Pap? <input type="checkbox"/> Yes <input type="checkbox"/> No Year: _____ Type: _____ Treatment Method: _____	
Part 7A: INDICATION FOR PAP TEST	
<input type="checkbox"/> Screening <input type="checkbox"/> Surveillance <input type="checkbox"/> No Pap <input type="checkbox"/> No Cervical Service <input type="checkbox"/> Non-program Pap, Referred in for Diagnostic Evaluation <input type="checkbox"/> Pap after Primary HPV+ <input type="checkbox"/> Unknown	
Part 7B: RISK FOR CERVICAL CANCER (HPV, tobacco use, HIV, long-term use of birth control, 3 or more childbirths)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Assessed/Unknown	
Part 7C: PELVIC INFORMATION	Part 7D: PAP TEST (Bold results require Work-up and completion of Form 274C)
Facility Name: _____	Facility Name: _____
Type of exam: <input type="checkbox"/> Pelvic <input type="checkbox"/> Visual Vaginal/Perineal	Date Pap Test Performed: ____/____/____
Date of exam: ____/____/____	Paid by Take Charge! Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Paid by Take Charge! Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date Provider Received Result: ____/____/____
Results of Pelvic Exam	Date Client Notified: ____/____/____
<input type="checkbox"/> Abnormal Pelvic (<i>suspicious for cervical cancer</i> <input type="checkbox"/> yes <input type="checkbox"/> no)	Specimen Adequacy: <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Unknown
<input type="checkbox"/> Normal	Results of Pap Test:
<input type="checkbox"/> Not Done–Normal PE in past 12 months (<i>attach records</i>)	<input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> ASC-US
<input type="checkbox"/> Not Done – Other/Unknown Reason	<input type="checkbox"/> AGC (Atypical Glandular Cells) Changes <input type="checkbox"/> ASC-H
<input type="checkbox"/> Not Indicated/Not Needed	<input type="checkbox"/> AIS (Adenocarcinoma In Situ) <input type="checkbox"/> HSIL
<input type="checkbox"/> Refused	<input type="checkbox"/> Squamous Cell Carcinoma <input type="checkbox"/> Result Pending
Clinical Comments: (<i>Notes are not entered into database</i>)	<input type="checkbox"/> LSIL includes HPV, Mild Dysplasia, CIN1 <input type="checkbox"/> Unsatisfactory
	<input type="checkbox"/> Negative for Intraepithelial Lesion/Malignancy <input type="checkbox"/> Other (<i>specify</i>)
	<input type="checkbox"/> Infection/Inflammation/Reactive
	<input type="checkbox"/> Result Unknown - Presumed Abnormal -Pap Test from Non Take Charge source
Part 7E: INDICATION FOR HPV TEST	7F: HPV TEST INFORMATION
<input type="checkbox"/> Screening/Co-test	HPV Test Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Reflex	Date of HPV Test: ____/____/____
<input type="checkbox"/> Test Not Done	Paid by Take Charge! Program? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Unknown	HPV Test Result: <input type="checkbox"/> Positive - Genotype Not Done/Unknown <input type="checkbox"/> Negative
	<input type="checkbox"/> Positive - Positive Genotype <input type="checkbox"/> Unknown
	<input type="checkbox"/> 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).	
<input type="checkbox"/> Yes - Needed or Planned (<i>mark type of work-up below</i>)	
<input type="checkbox"/> Cold Knife Cone (CKC)	<input type="checkbox"/> Endocervical Curettage (ECC)
<input type="checkbox"/> Colposcopy with Biopsy	<input type="checkbox"/> LEEP
<input type="checkbox"/> Colposcopy w/o Biopsy	<input type="checkbox"/> HPV Test
<input type="checkbox"/> Other Biopsy	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> 4 Month Short-Term Follow-up	<input type="checkbox"/> Repeat Pap Test Immediately
<input type="checkbox"/> 6 Month Short-Term Follow-up	<input type="checkbox"/> Follow Routine Screening
<input type="checkbox"/> No - Not needed -	
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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not sure <input type="checkbox"/> Refused	
Do you now smoke cigarettes? <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all <input type="checkbox"/> Don't know/Not sure <input type="checkbox"/> Refused	
Do you currently use any other type of tobacco such as cigars, pipes, or smokeless tobacco? <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all <input type="checkbox"/> Don't know/Not sure <input type="checkbox"/> Refused	
Do you currently use e-cigarettes or any other type of vapor products? <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all <input type="checkbox"/> Don't know/Not sure <input type="checkbox"/> Refused	
Do you live with anyone who uses tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was a fax referral for Quitline (Tobacco cessation) offered to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____	
Was the fax referral accepted by the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____	
Clinician completing the screening must sign and date after the form is completed.	
Examiner's Signature: _____	Date: ____/____/____