

Follow up, Diagnostic, and Treatment ODH Form No. 274C

Check One: **BREAST** **CERVICAL**

Last Name: _____ **First:** _____ **MI:** _____ **Maiden:** _____

DOB: / / **Screening Location:** _____ **Screening Date:** / /

Procedure (check One): <input type="checkbox"/> Mammogram <input type="checkbox"/> Additional Mam Views <input type="checkbox"/> Biopsy <input type="checkbox"/> FNA <input type="checkbox"/> Ultrasound <input type="checkbox"/> Film Comparison <input type="checkbox"/> MRI <input type="checkbox"/> Surg Consult <input type="checkbox"/> Consult Repeat CBE <input type="checkbox"/> Colposcopy <input type="checkbox"/> Cone <input type="checkbox"/> GYN Consult <input type="checkbox"/> Hysterectomy <input type="checkbox"/> LEEP <input type="checkbox"/> Other Biopsy <input type="checkbox"/> ECC/Endocervical Curettage <input type="checkbox"/> CKC/Cold Knife Cone Date Requested: _____ / _____ / _____ Procedure Facility: _____ Date Performed: _____ / _____ / _____ Paid by: <input type="checkbox"/> Take Charge <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____ Results: <input type="checkbox"/> Benign Finding <input type="checkbox"/> Normal <input type="checkbox"/> Negative <input type="checkbox"/> AGC <input type="checkbox"/> Negative for Intra. Lesion or Malig <input type="checkbox"/> HSIL <input type="checkbox"/> LSIL <input type="checkbox"/> Discrete Palp Mass - Susp for Cancer <input type="checkbox"/> ASC-US <input type="checkbox"/> CINI/Mild Dysplasia <input type="checkbox"/> CINII/Moderate Dysplasia <input type="checkbox"/> ASC-H <input type="checkbox"/> CINIII/CIS <input type="checkbox"/> Invasive Breast Cancer <input type="checkbox"/> Squamous Cell Carcinoma <input type="checkbox"/> Invasive Cervical Cancer Date Results Received: _____ / _____ / _____ Recommendation & Timing: (6 mo/3 mo/1 mo/ASAP) _____ / _____ / _____ Date Client Notified: / /	Procedure (check One): <input type="checkbox"/> Mammogram <input type="checkbox"/> Additional Mam Views <input type="checkbox"/> Biopsy <input type="checkbox"/> FNA <input type="checkbox"/> Ultrasound <input type="checkbox"/> Film Comparison <input type="checkbox"/> MRI <input type="checkbox"/> Surg Consult <input type="checkbox"/> Consult Repeat CBE <input type="checkbox"/> Colposcopy <input type="checkbox"/> Cone <input type="checkbox"/> GYN Consult <input type="checkbox"/> Hysterectomy <input type="checkbox"/> LEEP <input type="checkbox"/> Other Biopsy <input type="checkbox"/> ECC/Endocervical Curettage <input type="checkbox"/> CKC/Cold Knife Cone Date Requested: _____ / _____ / _____ Procedure Facility: _____ Date Performed: _____ / _____ / _____ Paid by: <input type="checkbox"/> Take Charge <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____ Results: <input type="checkbox"/> Benign Finding <input type="checkbox"/> Normal <input type="checkbox"/> Negative <input type="checkbox"/> AGC <input type="checkbox"/> Negative for Intra. lesion or Malig <input type="checkbox"/> HSIL <input type="checkbox"/> LSIL <input type="checkbox"/> Discrete Palp Mass - Susp for Cancer <input type="checkbox"/> ASC-US <input type="checkbox"/> CINI/Mild Dysplasia <input type="checkbox"/> CINII/Moderate Dysplasia <input type="checkbox"/> ASC-H <input type="checkbox"/> CINIII/CIS <input type="checkbox"/> Invasive Breast Cancer <input type="checkbox"/> Squamous Cell Carcinoma <input type="checkbox"/> Invasive Cervical Cancer Date Results Received: _____ / _____ / _____ Recommendation & Timing: (6 mo/3 mo/1 mo/ASAP) _____ / _____ / _____ Date Client Notified: / /
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Final Diagnosis: Not Cancer Cancer Copy of Surgical Pathology Report Attached

Status of Diagnosis: Complete Deceased Pending Refused Lost to Follow-up

Date of Diagnosis: _____ / _____ / _____

Treatment Status: Treatment Started Pending Refused Lost to Follow-up

Date Treatment Started / / **Next Mammogram/Pap Due:** / /

/ / Copy sent to TakeCharge upon completion of Diagnosis / / Original Retained in Client Record

Clinician Signature: _____ **Title** _____ **Date:** / /

Print Name: _____ **Medicaid Number:** _____



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Mammogram Additional Mam Views Biopsy

FNA Ultrasound Film Comparison MRI

Surg Consult Consult Repeat CBE Colposcopy

Cone GYN Consult Hysterectomy LEEP

Other Biopsy ECC/Endocervical Curettage

CKC/Cold Knife Cone

Date Requested: _____ / _____ / _____

Procedure Facility: _____

Date Performed: _____ / _____ / _____

Paid by: Take Charge Medicaid Other _____

Results:

Benign Finding Normal Negative AGC

Negative for Intra. Lesion or Malig HSIL LSIL

Discrete Palp Mass - Susp for Cancer ASC-US

CINI/Mild Dysplasia CINII/Moderate Dysplasia

ASC-H CINIII/CIS Invasive Breast Cancer

Squamous Cell Carcinoma Invasive Cervical Cancer

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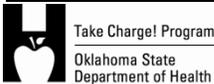
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