

Follow-up, Diagnostic, and Treatment Form

CIRCLE ONE: BREAST CERVICAL

Last Name: _____		First: _____		MI: _____		Maiden: _____	
DOB: _____		Screening Location: _____		Screening Date: _____			
Procedure: _____ Date Requested: ____/____/____ Procedure Facility: _____ Date Performed: ____/____/____ Paid by: <input type="checkbox"/> Take Charge Voucher# _____ <input type="checkbox"/> Medicaid Results: _____ Date Results Received: ____/____/____ Recommendation and Timing (6 mo, 3 mo, 1 mo, ASAP) _____ Date Client Notified: ____/____/____				Procedure: _____ Date Requested: ____/____/____ Procedure Facility: _____ Date Performed: ____/____/____ Paid by: <input type="checkbox"/> Take Charge Voucher# _____ <input type="checkbox"/> Medicaid Results: _____ Date Results Received: ____/____/____ Recommendation and Timing (6 mo, 3 mo, 1 mo, ASAP) _____ Date Client Notified: ____/____/____			
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Final Diagnosis: <input type="checkbox"/> Not Cancer <input type="checkbox"/> Cancer		<input type="checkbox"/> Copy of surgical path report attached					
Status of Diagnosis: <input type="checkbox"/> Complete <input type="checkbox"/> Deceased		<input type="checkbox"/> Pending <input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> Refused					
Date of Diagnosis: ____/____/____							
Treatment Status: <input type="checkbox"/> Treatment started <input type="checkbox"/> Pending		<input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> Refused					
Date Treatment Started: _____		Next Mammogram/Pap Due: _____					
____/____/____ Copy sent to TC upon completion of DX				____/____/____ Original Retained in Client Record			
Clinician Signature: _____				Date: _____			
Print Name: _____				Medicaid Number: _____			



Oklahoma State
Department of Health