NC BREAST AND CERVICAL CANCER CONTROL PROGRAM (NC BCCCP)
PATIENT NAVIGATION-ONLY FORM – FAX to (919) 870-4812

Patient ID: _____ NC BCCCP Provider Code: _____

First Contact Date: (MM DD YYYY) _____/_____/_____	Type of Contact: ☐ Face-to-Face ☐ Telephone ☐ Email ☐ Voicemail ☐ Text ☐ Other

Client Demographics

Name:

Date of Birth: / /	Phone Number: ( )	Alternative Number: ( )

Street Address		Apt. #

City:	Zip:	County of Residence:

Mailing Address: ☐ Same as Home Address

City:	Zip:	Email:

Race (check all that apply)	☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown/Prefer not to Answer
Ethnicity	Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Prefer Not to Answer

Barriers Identified (At Least ONE Must Be Checked)

☐ Trouble scheduling appointment ☐ No healthcare provider ☐ Difficulty getting time off work ☐ Insurance issues
☐ Transportation ☐ Family care issues ☐ Needs education on screening and/or diagnostic procedures
☐ Other_____

SECOND Patient Contact

Second Contact Date: (MM DD YYYY) _____/_____/_____	Type of Contact: ☐ Face-to-Face ☐ Telephone ☐ Email ☐ Voicemail ☐ Text ☐ Other

Clinical Services Completed **(*All screening results with an asterisk (*) require diagnostic work-up)**

Mammogram Date: _____/_____/_____
☐ Screening ☐ Diagnostics
Results:
☐ Negative (BI-RADS 1)
☐ Benign Findings (BI-RADS 2)
☐ Probably Benign; short term follow suggested (BI-RADS 3)
☐ * Suspicious Abnormality, consider biopsy (BI-RADS 4)
☐ * Highly Suggestive of Malignancy (BI-RADS 5)
☐ * Assessment Incomplete; additional imaging req'd (BI-RADS 0)

HPV Test Date: _____/_____/_____
HPV Results: ☐ Positive ☐ Negative ☐ Positive w/Type 16 or 18 ☐ Positive w/ Negative genotyping ☐ Unknown

Cervical Cytology Test Date: _____/_____/_____
Cervical Cytology Results:
☐ Negative for Intraepithelial Lesion or Malignancy
☐ * Squamous Cell Carcinoma
☐ Infection/Inflammation/Reactive Changes
☐ * Atypical Glandular Cells
☐ Atypical Squamous Cells of Undetermined Significance (ASC-US)
☐ *Adenocarcinoma in Situ (AIS)
☐ Low Grade SIL (including HPV changes)
☐ Adenocarcinoma
☐ * Atypical Squamous Cells Cannot Exclude HSIL (ASC-H)
☐ * High Grade SIL ☐ Unsatisfactory - Need Re-Pap

Diagnostic Services Completed:

☐ Yes - Breast (Dx Results Date): _____/_____/_____
☐ Yes - Cervical (Dx Results Date): _____/_____/_____
☐ No Work-Up Needed
☐ Lost to Follow-Up
☐ Patient Refused

Final Diagnosis:

Breast Cancer Diagnosis:
☐ No Cancer
☐ Invasive ☐ DCIS ☐ LCIS
Diagnosis Date: ____/_____/_____
Treatment Date: _____/____ /_____

Cervical Cancer Diagnosis:
☐ No Cancer
☐ Invasive ☐ CIN 3/ CIS
☐ CIN 2 ☐ CIN 1
Diagnosis Date: _____/_____/_____
Treatment Date: _____ /_____/_____

Patient Navigation Completed? ☐ Yes ☐ No	**Date Completed: / /**	**Provider:**