NC BREAST AND CERVICAL CANCER PATIENT NAVIGATION - ONLY FORM

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 Click or tap here to enter text. (Last) Click or tap here to enter text. (First) Click or tap here to enter text. (M.I.)

Date of Birth: (MM DD YYYY) _______/________/________	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 ☐ Unknown

Pap Test Date: ______/_________/__________
Pap 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:	Cervical Cancer Diagnosis:
☐ No Cancer	☐ No Cancer
☐ Invasive ☐ DCIS ☐ LCIS	☐ Invasive ☐ CIN 3/ CIS
	☐ CIN 2 ☐ CIN 1
Diagnosis Date: ____/______/______	Diagnosis Date: _____/_____/________
Treatment Date: _____/_____/_____	Treatment Date: _____/______/_______

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