

**NC BREAST AND CERVICAL CANCER CONTROL PROGRAM (NC BCCCP)
PATIENT NAVIGATION-ONLY FORM**

Patient ID: _____

NC BCCCP Provider Code: _____

First Contact Date: (MM DD YYYY) ____/____/____	Type of Contact: <input type="checkbox"/> Face-to-Face <input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Voicemail <input type="checkbox"/> Text <input type="checkbox"/> Other
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Client Demographics

Name:		
Date of Birth: ____/____/____	Phone Number: (____) _____	Alternative Number: (____) _____
Street Address	Apt. #	
City:	Zip:	County of Residence:
Mailing Address: <input type="checkbox"/> Same as Home Address		
City:	Zip:	Email:

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

Barriers Identified (At Least ONE Must Be Checked)

<input type="checkbox"/> Trouble scheduling appointment <input type="checkbox"/> No healthcare provider <input type="checkbox"/> Difficulty getting time off work <input type="checkbox"/> Insurance issues <input type="checkbox"/> Transportation <input type="checkbox"/> Family care issues <input type="checkbox"/> Needs education on screening and/or diagnostic procedures <input type="checkbox"/> Other _____

SECOND Patient Contact

Second Contact Date: (MM DD YYYY) ____/____/____	Type of Contact: <input type="checkbox"/> Face-to-Face <input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Voicemail <input type="checkbox"/> Text <input type="checkbox"/> Other
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Clinical Services Completed (*All screening results with an asterisk (*) require diagnostic work-up)

Mammogram Date: ____/____/____ <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostics Results: <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign; short term follow suggested (BI-RADS 3) <input type="checkbox"/> * Suspicious Abnormality, consider biopsy (BI-RADS 4) <input type="checkbox"/> * Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> * Assessment Incomplete; additional imaging req'd (BI-RADS 0)	HPV Test Date: ____/____/____ HPV Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Positive w/Type 16 or 18 <input type="checkbox"/> Positive w/ Negative genotyping <input type="checkbox"/> Unknown Cervical Cytology Test Date: ____/____/____ Cervical Cytology Results: <input type="checkbox"/> Negative for Intraepithelial Lesion or Malignancy <input type="checkbox"/> * Squamous Cell Carcinoma <input type="checkbox"/> Infection/Inflammation/Reactive Changes <input type="checkbox"/> * Atypical Glandular Cells <input type="checkbox"/> Atypical Squamous Cells of Undetermined Significance (ASC-US) <input type="checkbox"/> *Adenocarcinoma in Situ (AIS) <input type="checkbox"/> Low Grade SIL (including HPV changes) <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> * Atypical Squamous Cells Cannot Exclude HSIL (ASC-H) <input type="checkbox"/> * High Grade SIL <input type="checkbox"/> Unsatisfactory - Need Re-Pap
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Diagnostic Services Completed: Final Diagnosis:

<input type="checkbox"/> Yes - Breast (Dx Results Date): ____/____/____ <input type="checkbox"/> Yes - Cervical (Dx Results Date): ____/____/____ <input type="checkbox"/> No Work-Up Needed <input type="checkbox"/> Lost to Follow-Up <input type="checkbox"/> Patient Refused	Breast Cancer Diagnosis: <input type="checkbox"/> No Cancer <input type="checkbox"/> Invasive <input type="checkbox"/> DCIS <input type="checkbox"/> LCIS Diagnosis Date: ____/____/____ Treatment Date: ____/____/____	Cervical Cancer Diagnosis: <input type="checkbox"/> No Cancer <input type="checkbox"/> Invasive <input type="checkbox"/> CIN 3/ CIS <input type="checkbox"/> CIN 2 <input type="checkbox"/> CIN 1 Diagnosis Date: ____/____/____ Treatment Date: ____/____/____
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Patient Navigation Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Completed: ____/____/____	Provider: _____
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