Florida Breast and Cervical Cancer Early Detection Program

Patient Reporting Form (PRF)

☐ **Enrollee into FBCCEDP**

Lead Region: PASCO _____ **Date Enrolled:** _____

RC Initials: _____ **RC Date Reviewed:** _____

GENERAL INFORMATION

1. Basic Demographics

Full Name: _____
Last *First* *Middle Name* *Maiden Name*

Date of Birth: ____/____/_____ **ID:** _____ **Telephone:** _____

Mailing Address: _____ **Email Address:** _____

_____
City *County* *ZIP*

Hispanic? Yes ☐ No ☐

Race: (✓ all that apply)

☐ White	☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American	☐ American Indian or Alaska Native
☐ Asian	☐ Unknown

Primary Language: _____

2. Personal Health Information and Referrals

Height (inches): _____ **Weight (pounds):** _____

Has medical personnel ever told the client she was: (✓ all that apply)

☐ Pre-diabetic	☐ High blood pressure
☐ Diabetic	☐ High blood cholesterol
☐ Exercising 5x weekly	☐ Eating 5 servings of fruits/vegetables daily

Referred to WISEWOMAN Services: Yes ☐ No, not referred ☐ Declined referral ☐

Tobacco Use *(including vaping, e-cigarettes or similar products)*: Daily ☐ Some Days ☐ Not at all ☐ Declined to answer ☐

Referred to Quitline: Yes ☐ No, not referred ☐ Declined referral ☐

3. Screening Status, Undocumented Status and How Client Learned of Program

Screening Status: Initial ☐ Rescreen ☐ Short-term Follow-up ☐

Undocumented: Yes ☐ No ☐

Client with disability: ☐ ☐

How did client learn about the program?

☐ ACS	☐ Billboards	☐ Brochures
☐ Bus wraps/bench/placards	☐ CHD	☐ Community
☐ Educational Session	☐ Family/Friend	☐ FQHC Name:
☐ In-reach	☐ Internet	☐ Medical Office
☐ Newspaper	☐ Outreach	☐ Postcard
☐ Radio	☐ Social Media	☐ Television
Other:		

Name: _____ DOB: ____/____/_____ Lead Region: PASCO

BREAST

4. Breast Risk Information and History *(Yes/No answers should be chosen if risk assessed and determined by provider)*

	Yes	No	Not Assessed/Unknown
High Risk for Breast Cancer:	☐	☐	☐
First degree relative has/had breast cancer:	☐	☐	
Has client ever had: breast cancer?	☐	☐	

	Yes	No
Symptoms:	☐	☐
a previous mammogram?	☐	☐

Date of previous mammogram: ____/____/_____

5. Clinical Breast Exam

	Not performed	Normal/ Benign	Abnormality Suspicious for Cancer
CBE Result:	☐	☐	☐

CBE Provider #: _____

Referring Provider? ☐ **Yes** ☐ **No**

CBE Screening Date: ____/____/____

CBE Paid by FBCCEDP: ☐ **Yes** ☐ **No**

Additional Breast Procedures for CBE

☐ Additional procedures needed or planned

☐ Additional procedures not needed or planned

6. Mammogram

Mam Provider #: _____

Mam Screening Date: ____/____/_____

Mam Paid by FBCCEDP: ☐ **Yes** ☐ **No**

Indication for Mammogram

☐ Screening

☐ Diagnostic (Select one):

- ☐ Bloody or serous nipple discharge
- ☐ Cystic or solid mass
- ☐ First degree relative has/had breast cancer
- ☐ Nipple or areola scaliness
- ☐ Radiologist requested
- ☐ Skin dimpling or retraction
- ☐ Other suspicious findings (specify): _____

☐ Non-program mammogram.
Referred in for diagnostic evaluation
Breast Diagnostic Referral Date: ____/____/____

☐ No mammogram

☐ No breast service

☐ Unknown

Mammogram Result

☐ Negative (BI-RADS 1)

☐ Benign Finding (BI-RADS 2)

☐ Probably Benign/STFU suggested (BI-RADS 3)

☐ Unsatisfactory

☐ Result Pending

☐ Result unknown, presumed abnormal, mam from non-funded source

☐ Suspicious Abnormality (BI-RADS 4)

☐ Highly Suggestive of Malignancy (BI-RADS 5)

☐ Need evaluation or film comparison (BI-RADS 0)

Additional Procedures for Mammogram

☐ Additional procedures needed or planned

☐ Additional procedures not needed or planned

☐ Need or plan for additional procedures not yet determined.

7. Screening MRI (high-risk only)

MRI Pre-Authorization Date: _____

Central Office Nurse: _____

Screening MRI Provider#: _____

Screening MRI Date: ____/____/_____

Screening MRI Paid by FBCCEDP: ☐ Yes ☐ No

Screening MRI Result

☐ Negative (BI-RADS 1)

☐ Benign Finding (BI-RADS 2)

☐ Probably Benign indicated (BI-RADS 3)

☐ Unsatisfactory

☐ Result Pending

☐ Not done

☐ Suspicious (BI-RADS 4)

☐ Highly Suggestive of Malignancy (BI-RADS 5)

☐ Known Malignancy (BI-RADS 6)

☐ Need Additional Imaging Evaluation (BI-RADS 0)

Additional Procedures for Screening MRI

☐ Additional procedures needed or planned

☐ Additional procedures not needed or planned

☐ Need or plan for additional procedures not yet determined.

Next mammogram date: ____/____/_____

Name: _____ DOB: ____/____/_____ Lead Region : PASCO

CERVICAL

11. Cervical Cancer Risk Information and History (Yes/No answers should be chosen if risk assessed and determined by provider)

	Yes	No	Not Assessed/Unknown		Yes	No
Risk for Cervical Cancer:	☐	☐	☐	**Previous Dx'd Cervical Cancer ?**	☐	☐

	Yes	No	Unknown	
Previous Pap Test?	☐	☐	☐	**Date of Previous Pap?** _____

12. Pap

Indication for Pap

☐ Screening
☐ Surveillance
☐ Non-program Pap. Referred in for diagnostic evaluation
Cervical Diagnostic Referral Date: ____/____/_____
☐ No Pap
☐ No cervical service
☐ Pap after primary HPV+
☐ Unknown

Pap Provider #: _____

Pap Screening Date: ____/____/_____

Pap Paid by FBCCEDP: ☐ **Yes** ☐ **No**

Specimen Type: ☐ Conventional Smear ☐ Liquid Based

Specimen Adequacy: ☐ Satisfactory ☐ Unsatisfactory

Pap Result

☐ Negative for intraepithelial lesion or malignancy
☐ Infection/Inflammation/Reactive Changes
☐ Atypical squamous cells of undetermined significance (ASC-US)
☐ Low Grade SIL (including HPV changes)
☐ Other _____
☐ Unsatisfactory
☐ Result Pending

☐ Atypical squamous cells cannot exclude HSIL (ASC-H)
☐ High Grade SIL
☐ Squamous Cell Carcinoma
☐ Atypical Glandular Cells
☐ Adenocarcinoma In Situ (AIS)
☐ Adenocarcinoma
☐ Result Unknown, presumed abnormal, Pap test from non-program funded source

Diagnostic Work-up Planned for Cervical Dysplasia or Cancer:

☐ Diagnostic work-up planned on basis of abnormal Pap test or pelvic exam
☐ Diagnostic work-up not planned
☐ Diagnostic work-up planned not yet determined

Next Pap date: ____/____/_____

13. HPV

Indication for HPV

☐ Co-Test/Screening
☐ Reflex (follow-up test after screening Pap)
☐ Test not done
☐ Unknown

HPV Provider #: _____

HPV Screening Date: ____/____/_____

HPV Paid by FBCCEDP: ☐ **Yes** ☐ **No**

HPV Result

☐ Positive with genotyping not done/Unknown
☐ Negative
☐ Positive with positive genotyping (types 16 or 18)
☐ Positive with negative genotyping (positive HPV, but not types 16 or 18)
☐ Unknown