SCREENING INTAKE FORM
MISSISSIPPI BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (MSBCCEDP)

Original Enrollment Date ____/____/____ (mm dd yyyy)
Enrollment Site: _____

PERSONAL DATA

Annual Enrollment Date _____/_____/_____ (mm dd yyyy)

Patient's Name _____ (Last First Middle Maiden) Date of Birth:_____/_____/_____ (mm dd yyyy)

Social Security Number_____ Monthly Income $_____ Household Size_____ Age_____

Address: _____ (Number and Street City State Zip)

County of Residence_____ Phone Number (Day)_____ Phone Number (Alternate)_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Referral Source**: ☐ Self ☐ Other ☐ Provider ☐ Outreach ☐ MBCCP Reminder

Race (Check all that apply): ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

Health Insurance (can check more than one) ☐ Uninsured ☐ Underinsured ☐ Medicare Part A only ☐ Medicare Part A & B ☐ Private insurance _____ ☐ Medicaid

Discussed need to RTC for annual exam? ☐ Yes ☐ No **Smoker?** ☐ Yes ☐ No (If yes, refer to Hot Line at 1-800-784-8669)

Case Management Services Needed? ☐ Yes ☐ No (If yes, contact MSBCCEDP at 601-576-7466)

BREAST SCREENING DATA
(To be completed by Clinician)

Funding Source:_____
(18 – 49 years of age)

Clinic/Provider _____

Prior Mammogram? ☐ Yes, Date:_____/_____/_____ (mm dd yyyy) ☐ No

Breast Symptoms? ☐ Yes ☐ No
High Risk for Breast Cancer? ☐ Yes ☐ No ☐ Not assessed/unknown

CBE Results: **Date of CBE:**_____/_____/_____ (mm dd yyyy)

☐ Normal ☐ Other_____
☐ Benign
☐ Benign findings, NOT suspicious for cancer (Dx Benign)
☐ Discrete palpable mass, suspicious for cancer*
☐ Bloody or serous nipple discharge (not green, black, or white)*
☐ Nipple or areola scaliness*
☐ Skin dimpling or retraction*
☐ Not Done-Normal CBE in past 12 months

***Requires surgeon referral or ultrasound and/or diagnostic mammogram.**
Funding Source:_____

Additional Mammogram Views/ Date _____/_____/_____ (mm dd yyyy)

☐ Repeat Mammogram-Type of Diagnostic _____
☐ Ultrasound
☐ Film Comparison
☐ No additional tests needed
☐ Unknown

Funding Source:_____

Surgical Consult to: _____

Appointment Date:_____/_____/_____ (mm dd yyyy)

Indication for initial Mammogram: Date: ____/_____/_____ (mm dd yyyy)
Site: _____

☐ Routine Screening Mammogram
☐ Diagnostic Mammogram or short-term follow-up mammogram
☐ Non-program Mammogram/Referred in for diagnostic evaluation
☐ No Mammogram
☐ No Breast Services done
☐ Unknown

Initial Mammogram Results
☐ Negative
☐ Benign finding
☐ Probably Benign
☐ Suspicious abnormal (Consider biopsy)**
☐ Highly suggestive of malignancy**
☐ Additional work-up required**

****Requires surgeon referral/Use MSBCCEDP Breast Follow-up Referral Form 717.**

Funding Source: _____

Screening MRI Results (High risk patients only with Prior Authorization)
Date:_____/_____/_____ (mm dd yyyy)

☐ Negative (Category 1)
☐ Benign Finding (Category 2)
☐ Probably Benign (Category 3)
☐ Suspicious (Category 4)**
☐ Highly Suggestive of Malignancy (Category 5)**
☐ Known Malignancy (Category 6)**
☐ Incomplete need additional imaging/evaluation (Category 0)**
☐ Results Pending
☐ Not done
☐ Unknown

If a screening MRI is needed, please contact MSBCCEDP for Prior Authorization at 601-576-7466.

****Requires surgeon referral, use MSBCCEDP Breast Follow-up Referral Form 717.**

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Patient's Last Name _____ First Name _____ Birth Date _____/_____ /_____
mm dd yyyy

Enrollment Site/Clinic Name: _____ Facility/Provider Name_____

CERVICAL SCREENING DATA
(To be completed by Clinician)

Funding Source:_____
(18-49 years of age)

Clinic/Provider _____

Previous Pap test? ❑ Yes, Date:_____/_____/_____ ❑ No
mm dd yyyy

Hysterectomy? ❑ Yes ❑ No
Was Hysterectomy due to Cervical Cancer? ❑ Yes ❑ No ❑ Unknown
High Risk for Cervical Cancer? ❑ Yes ❑ No
❑ Not Assessed/Unknown

Pelvic Exam Results: **Date:** _____/_____/_____
mm dd yyyy

❑ Normal
❑ Abnormal Pelvic
❑ Abnormal/Not Suspicious for Cancer
❑ Abnormal/Suspicious for Cancer
❑ Not Done
❑ Not Indicated/Not Needed
❑ Not Done/Normal PE in Past 12 Months
❑ Refused

Indication for HPV Test: **Date:** _____/_____/_____
mm dd yyyy

❑ Co-Test/Screening
❑ Reflex
❑ Test Not Done
❑ Unknown

HPV Test Result: **Date:**_____/_____/_____
mm dd yyyy

❑ Positive with Genotyping Not Done/Unknown
❑ Negative
❑ Positive with Positive Genotyping
❑ Positive with Negative Genotyping
❑ Unknown

Funding Source_____

Patient Navigation Reimbursed by NBCCEDP funds?
❑ Yes ❑ No ❑ Unknown

Navigation Only? ❑ Yes ❑ No

Funding Source: _____

Indication for Pap Test: **Date:**_____/_____/_____
mm dd yyyy

❑ Routine Pap
❑ Patient Monitored for Previous Abnormal Pap
❑ Non-program Pap/Referred in for Diagnostic Evaluation
❑ No Pap
❑ No Cervical Services Done
❑ Pap after Primary HPV +
❑ Unknown

Pap Test Results: **Date:**_____/_____/_____
mm dd yyyy

❑ Negative for Intraepithelial Lesion or Malignancy
❑ Infection/Inflammation Reactive Changes
❑ ASC-US*
❑ Low Grade SIL (Including HPV Changes)*
❑ ASC-H*
❑ High Grade SIL*
❑ Squamous Cell Carcinoma*
❑ Atypical Glandular Cells*
❑ Adenocarcinoma In-situ(AIS)*
❑ Adenocarcinoma*
❑ Other_____
❑ Unsatisfactory (Repeat Pap)
❑ Result Pending
❑ Unknown (Presumed Abnormal)

Funding Source _____

***Requires surgeon referral/Use MSBCCEDP Cervical Follow-up Referral Form 691.**

GYN Consult: _____
Phone:_____

Appointment Date:_____/_____/_____
mm dd yyyy