American Indian Cancer Foundation's
Screen Our Circle

Documentation of Cervical Clinical Services

Last Name:	First Name:	MI:	Maiden Name:
Clinic:	☐ New Screen. ☐ Follow-Up ☐ Rescreen		Enrollment #:

FAMILY HISTORY *(Required)*

1. Client at high risk for cervical cancer?
   - ☐ Yes (e.g. client was exposed to diethylstilbestrol (DES) or is considered immunocompromised)
   - ☐ No
   - ☐ Not assessed

PAP TEST, PELVIC EXAM, AND HPV TEST *(Required)*

2. Prior Pap test: ☐ Yes ☐ No ☐ Unknown Prior Pap test date: _____ (*MM/DD/YYYY*)
3. Indication for today's Pap test:
   - ☐ Routine Pap test
   - ☐ Client under surveillance for a previous abnormal test. Also considered a "rescreened" client
   - ☐ Pap test done by a non-program funded provider, client referred in for diagnostic evaluation
     Date of referral: _____ (*MM/DD/YYYY*)
   - ☐ Pap test done after primary HPV test positive
   - ☐ Pap test not done

Why was Pap test not done? ☐ Refused ☐ Not Needed ☐ Needed but not performed

4. Pelvic exam date:
(*MM/DD/YYYY*)
5. Today's Pap test date:
(*MM/DD/YYYY*)
   - ☐ 3 year (without HPV test)
   - ☐ 5 year (with HPV test)
6. What were today's Pap test results?
   - ☐ Negative (for intraepithelial lesion or malignancy)
   - ☐ Infection/Inflammation/Reactive Changes
   - ☐ Atypical Squamous Cells of Undetermined Significance (ASC-US)*
   - ☐ Low-Grade Squamous Intraepithelial Lesion (LSIL)*
   - ☐ Atypical Squamous Cells cannot exclude HSIL (ASC-H Beth2001)*
   - ☐ High-Grade Squamous Intraepithelial Lesion (HSIL)*
   - ☐ Squamous Cell Carcinoma*
   - ☐ Abnormal Glandular Cells (AGC)*
   - ☐ Adenocarcinoma in situ (AIS)
   - ☐ Adenocarcinoma
   - ☐ Result Pending
   - ☐ Results unknown, presumed abnormal, from non-program funded sources
   - ☐ Other Pap results:

***May require further diagnostic evaluation.**

7. Specimen adequacy?
   - ☐ Satisfactory
   - ☐ Unsatisfactory-Repeat Pap Required
8. Indication for HPV test:
   - ☐ Co-Test or Screening
   - ☐ Reflex
   - ☐ Not Done
   - ☐ Unknown
9. HPV Test Result:
   - ☐ Positive with genotyping not done
   - ☐ Negative
   - ☐ Positive with positive genotyping (types 16 or 18)
   - ☐ Positive with negative genotyping (positive HPV, but not types 16 or 18)
   - ☐ Not Done
10. HPV test date: _____ (*MM/DD/YYYY*)
11. Was the client referred for immediate cervical diagnostic workup to reach a final diagnosis?
    ☐ Yes ☐ No

Form Completed _____ (*MM/DD/YYYY*) **Form Completed by:**

AICAF Use Only		
12. Which services were paid by AICAF?		
☐ Pelvic exam	☐ Colposcopy without biopsy	☐ Cone
☐ Pap test	☐ Colposcopy-directed biopsy/ECC	☐ Other:
☐ HPV test	☐ LEEP	