



CERVICAL DIAGNOSTICS DATA ENTRY TOOL

AGENCY OR SITE		eCaST ID		
LAST NAME	FIRST NAME	SSN	DATE OF BIRTH	AGE

COLPOSCOPY RESULT WITH BIOPSY/ECC RESULT:	DATE PERFORMED:
<input type="checkbox"/> Negative <input type="checkbox"/> Benign, HPV, condyloma, atypia <input type="checkbox"/> CIN I or mild dysplasia <input type="checkbox"/> CIN II or moderate dysplasia	<input type="checkbox"/> CIN III, CIS, AIS, or severe dysplasia <input type="checkbox"/> Invasive cervical carcinoma <input type="checkbox"/> Insufficient sample
LOCATION PERFORMED:	FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other

COLPOSCOPY WITHOUT BIOPSY RESULT:	DATE PERFORMED:
<input type="checkbox"/> Adequate Colpo/ Normal Appearing Cervix <input type="checkbox"/> Inadequate/ Abnormal/ Further Diagnostic Need	
LOCATION PERFORMED:	FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other

OTHER CERVICAL DX PROCEDURE:	DATE PERFORMED:
TYPE: <input type="checkbox"/> Cold Knife Cone (CKC) <input type="checkbox"/> Endometrial Biopsy (EMB only covered after AGC pap)	<input type="checkbox"/> Gyn Consult <input type="checkbox"/> LEEP/ LOOP <input type="checkbox"/> Polyp removal <input type="checkbox"/> Other (please specify)
RESULT: <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> CIN I or mild dysplasia <input type="checkbox"/> CIN II or moderate dysplasia	<input type="checkbox"/> CIN III, CIS, AIS, or severe dysplasia <input type="checkbox"/> Invasive cervical carcinoma <input type="checkbox"/> Insufficient results
LOCATION PERFORMED:	FUNDING: <input type="checkbox"/> WWC <input type="checkbox"/> Other

FINAL DIAGNOSIS STATUS:	
DIAGNOSTIC WORK-UP IS COMPLETE (choose one below): <input type="checkbox"/> Return for annual exam <input type="checkbox"/> Patient needs short-term follow-up in _____ months <input type="checkbox"/> Treatment needed <input type="checkbox"/> Further immediate diagnostic tests required	DIAGNOSTIC WORK-UP IS NOT COMPLETE (choose one below): <input type="checkbox"/> Lost to follow-up: Date: _____ <input type="checkbox"/> Refused: Date: _____ <input type="checkbox"/> Deceased: Date: _____

FINAL DIAGNOSIS: Required 60 days after first abnormal screening.	FINAL DIAGNOSIS DATE:
<input type="checkbox"/> Normal, benign reaction or inflammation <input type="checkbox"/> HPV, Condylomata or Atypia <input type="checkbox"/> CIN I or mild dysplasia	*Results require treatment! <input type="checkbox"/> *CIN II or moderate dysplasia <input type="checkbox"/> *CIN III, CIS, AIS, severe dysplasia
<input type="checkbox"/> *Invasive cervical carcinoma <input type="checkbox"/> Other (please specify):	
TREATMENT: Required when Final Diagnostic is abnormal. To be initiated within 60 days of Final Diagnosis.	TREATMENT DATE:
<input type="checkbox"/> Treatment pending <input type="checkbox"/> Treatment started: Date: _____	<input type="checkbox"/> Treatment not done (choose one below): <input type="checkbox"/> Lost to follow-up: Date: _____ <input type="checkbox"/> Refused: Date: _____ <input type="checkbox"/> Deceased: Date: _____
<input type="checkbox"/> Not medically indicated, not needed	
MEDICAID ELIGIBILITY: Required when Final Diagnostic is abnormal. To be initiated within 5 days of Final Diagnosis.	
<input type="checkbox"/> Eligible	<input type="checkbox"/> Not eligible: Reason _____

PROCEDURES

FINAL DIAGNOSIS SUMMARY