

CLINICAL CYCLE DATA ENTRY TOOL



AGENCY OR SITE		CLINICIAN NAME		eCaST ID		OFFICE VISIT DATE	
LAST NAME		FIRST NAME		SSN	DATE OF BIRTH		AGE
BREAST CANCER SCREENING				CERVICAL CANCER SCREENING			
MEDICAL HISTORY				MEDICAL HISTORY			
<input type="checkbox"/> WWC funded breast health education provided <input type="checkbox"/> Self reported breast symptoms <input type="checkbox"/> Prior diagnosis of breast cancer <input type="checkbox"/> Parent, sibling, or child has history of breast cancer Previous Mammogram <input type="checkbox"/> Yes (choose one): <input type="checkbox"/> Date known: _____ <input type="checkbox"/> Date unknown but <2 years <input type="checkbox"/> Date unknown but >2 years <input type="checkbox"/> No <input type="checkbox"/> Patient does not know Current Mammogram Reason <input type="checkbox"/> Routine screening mammogram <input type="checkbox"/> Short term follow-up <input type="checkbox"/> Mammogram not done <input type="checkbox"/> Abnormal CBE or new symptoms <input type="checkbox"/> Patient referred in for diagnostic eval.				<input type="checkbox"/> WWC funded cervical health education provided <input type="checkbox"/> History of CIN II/III or cervical cancer <input type="checkbox"/> HIV/Immunocompromised <input type="checkbox"/> DES Exposure Hysterectomy status <input type="checkbox"/> Hysterectomy due to cervical neoplasia/cancer <input type="checkbox"/> Hysterectomy with intact cervix <input type="checkbox"/> No hysterectomy <input type="checkbox"/> Hysterectomy unrelated to cervical neoplasia (e.g. fibroids) Previous Pap Test <input type="checkbox"/> Yes (choose one): <input type="checkbox"/> Date known: _____ <input type="checkbox"/> Date unknown but <5 years <input type="checkbox"/> Date unknown but >5 years <input type="checkbox"/> No <input type="checkbox"/> Patient does not know Current Pap Reason <input type="checkbox"/> Routine pap test <input type="checkbox"/> Short term follow-up <input type="checkbox"/> No pap test done <input type="checkbox"/> Patient referred in for diagnostic eval.			
SCREENING PROCEDURES *Requires immediate follow up				SCREENING PROCEDURES *Requires immediate follow up			
CBE				PELVIC			
Date performed: _____ Funding: <input type="checkbox"/> WWC <input type="checkbox"/> Other: _____ Location performed: _____ <input type="checkbox"/> Not suspicious for breast cancer <input type="checkbox"/> *Suspicious for breast cancer				Date performed: _____ Funding: <input type="checkbox"/> WWC <input type="checkbox"/> Other: _____ Location performed: _____ <input type="checkbox"/> Normal <input type="checkbox"/> *Abnormal cervical lesion			
MAMMOGRAM				PAP TEST			
Date performed: _____ Funding: <input type="checkbox"/> WWC <input type="checkbox"/> Other: _____ Location performed: _____ Type: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic <input type="checkbox"/> BI-RADS 1: Negative <input type="checkbox"/> BI-RADS 2: Benign <input type="checkbox"/> BI-RADS 3: Probably Benign <input type="checkbox"/> *BI-RADS 4: Suspicious abnormality <input type="checkbox"/> *BI-RADS 5: Highly suggestive of malignancy <input type="checkbox"/> *BI-RADS 0: Assessment is incomplete, need additional imaging				Date performed: _____ Funding: <input type="checkbox"/> WWC <input type="checkbox"/> Other: _____ Location performed: _____ Type: <input type="checkbox"/> Liquid based <input type="checkbox"/> Conventional <input type="checkbox"/> Negative for intraepithelial lesion or malignancy <input type="checkbox"/> Negative (with no ECC) <input type="checkbox"/> ASC-US <input type="checkbox"/> Low grade SIL encompassing HPV, mild dysplasia <input type="checkbox"/> ASC-US Adequacy: <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> *High grade SIL, moderate & severe dysplasia, CIS, AIS <input type="checkbox"/> *ASC-H <input type="checkbox"/> *Atypical glandular cells-AGC <input type="checkbox"/> *Invasive cervical carcinoma <input type="checkbox"/> Other (rare): _____			
				HPV			
				Date performed: _____ Funding: <input type="checkbox"/> WWC <input type="checkbox"/> Other: _____ Location performed: _____ <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Insufficient			
FOLLOW UP RECOMMENDATION				FOLLOW UP RECOMMENDATION			
<input type="checkbox"/> Follow routine screening <input type="checkbox"/> Patient needs short-term follow-up, client to return in _____ months <input type="checkbox"/> Screening or diagnostic procedures not complete because: <input type="checkbox"/> Pending screenings <input type="checkbox"/> Lost to follow-up, Date: _____ <input type="checkbox"/> Refused, Date: _____ <input type="checkbox"/> Client referred for further immediate work-up <input type="checkbox"/> Deceased, screening/diagnostics not complete				<input type="checkbox"/> Follow up per ASCCP screening guidelines <input type="checkbox"/> Pap/HPV in 5 years <input type="checkbox"/> Pelvic or Pap in 3 years <input type="checkbox"/> Patient needs short-term follow-up, client to return in _____ months <input type="checkbox"/> Pending screening(s) not complete <input type="checkbox"/> Client referred for further immediate workup <input type="checkbox"/> Lost to follow-up, Date: _____ <input type="checkbox"/> Refused, Date: _____ <input type="checkbox"/> Client referred for further immediate work-up <input type="checkbox"/> Deceased, screening/diagnostics not complete			