

# 2

## SCREENING SERVICES

### A. Enrollment and Screening Duties:

#### 1. Medical Service Provider Enrollment

Cancer control specialists will:

- Solicit and enroll all interested medical service providers in their geographic areas.
- Act as a liaison between the MCCP and the enrolled medical service providers in their geographic areas.
- Be responsible for answering providers' questions about client and program issues.
- Conduct an orientation for enrolled medical service providers.
- Submit a signed and completed provider enrollment packet to the address noted on the provider enrollment application.
- Ensure providers follow the Centers for Disease Control and Prevention (CDC) guidelines for comprehensive cancer screening.
- Ensure providers provide referral to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP) if necessary.

#### 2. Client Enrollment

Cancer control specialists will:

- Determine whether a person is eligible for services, either by telephone or an in-person interview and which screening service they need.
- Complete MCCP enrollment forms, ensuring the following:
  - Each client signs an "Informed consent and Authorization to Disclose Health Care Information". This form must be signed before any services can be provided.
  - Client screening history and risk assessment is completed.

#### 3. American Indian Enrollment

Together with subcontractors, local grassroots coalitions and the statewide Montana American Indian Women's Health Coalition (MAIWHC), cancer control specialists work to increase the number of American Indian individuals being screened through the MCCP per the American Indian Screening Initiative (AISI).

## **B. Tracking and Follow-up**

### **1. Screening through Diagnosis**

The cancer control specialists and enrolled medical service providers share equal responsibility for tracking and follow-up to ensure all clients complete the required diagnostic exams as scheduled.

The cancer control specialist must:

- Implement a referral, tracking and follow-up system covering and documenting a client's initial screening through diagnosis and, if necessary, to initiation of treatment.
- Ensure all clients complete the required diagnostic exams as scheduled and within the required timeframes.
- Notify a client of test results either by telephone, office visit or mail.
  - Do not use any means of communication that cannot ensure confidentiality.
  - Do not send test results to the client by postcard or fax, and do not leave results on an answering machine.

### **2. Abnormal Results**

Tracking and follow-up requirements for abnormal screening and diagnostic results include:

- Contact the client to discuss the type of follow-up needed or schedule an appointment, and inform the client of:
  - The nature of the suspected disease.
  - The need for further testing or follow-up care.
  - The choices (if available) of referrals for definitive diagnostic procedures after screening procedures have been performed.
  - Their responsibility to obtain follow-up care.
- Indicate on the MCCP screening form that a workup is planned and complete the abnormal screening form.
- Supply any other information requested by the MCCP state office on clients with abnormal test results.
- Document contact with the client's enrolled medical service provider in the client's record.

### **3. Rescreening**

Cancer control specialists will notify the client when rescreening is needed. Normal rescreening will occur based on MCCP guidelines and enrolled medical service provider recommendations.

#### **4. Clients “Lost to follow-up”**

Before considering a client “lost to follow-up” the cancer control specialist must:

- Make three attempts to contact a client. The first two attempts may be by phone or writing. The third or final attempt must be a letter sent by certified mail with a return receipt requested.
- Complete all attempts to contact a client within 6 weeks of receiving notice of abnormal results.
- Indicate on the MCCP data collection forms “lost to follow-up” under “Status of Final Diagnosis” or “Status of Treatment” when a client does not respond to contact attempts regarding the need for further diagnostic tests, initiation of treatment or when a client dies or moves before workup is started.

#### **5. Client Refusal of Follow-up Tests or Treatment**

If a client with an abnormal test result (suspicious for cancer) refuses diagnostic tests or treatment, the “MCCP Acknowledgement of Refusal to Consent to Diagnostic Tests or Treatment” form must be completed by the medical service provider and signed by the client. Cancer control specialists will act as a liaison to the client and provider if necessary.

Indicate on the MCCP data collection forms “Refused” under “Status of Final Diagnosis” or “Status of Treatment” when a client refuses to obtain further diagnostic tests, treatment or severs her relationship with the MCCP.

### **C. Clients Who Move**

#### **1. Within Montana or Out-of-State**

When a client moves, the cancer control specialist will refer the client to the Montana regional contractor or the out-of-state program nearest their new residence. It is the client’s responsibility to contact the new site for subsequent services, if needed, and to sign a copy of the “Informed Consent and Authorization to Disclose Health Care Information” form for release of medical information.

The cancer control specialist must:

- Notify the MCCP state office that the client has moved.
- Provide the client with copies of the screening results or obtain the client’s permission in writing to forward screening results as indicated by the client’s request.

## **D. Patient Navigation**

Patient navigation is the component of the MCCP which establishes brokers and maintains the system of clinical services (screening, diagnostic and treatment) and support services to clients.

The specific goal of patient navigation is to ensure MCCP clients receive timely and appropriate rescreening, diagnostic and treatment services. The priority population includes clients who have an abnormal screening test result or a diagnosis of cancer.

Key elements of patient navigation for the MCCP at all levels include:

- Assessment
- Planning
- Coordination
- Monitoring
- Evaluation
- Resource Development

The cancer control specialist is responsible for assessing the client's need for patient navigation services and, if necessary, developing and monitoring each client's plan for these services.

Cancer control specialists will:

- Contact the client to assess for patient navigation services within ten (10) working days of receiving the client's abnormal screening test result.
- Implement the "Patient Navigation Service Agreement Plan" within twenty (20) working days of assessing the client's need for patient navigation services, if needed.
- Refer clients diagnosed with breast or cervical cancer or pre-cancer to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP).
- Monitor and update the Patient Navigation Service Agreement Plan weekly until date of final diagnosis or application for the MBCCTP is made and treatment is initiated.
- Develop a list of available community resources in their multi-county areas.
- Develop formal and informal agreement with other entities in their multi-county areas to facilitate referrals for diagnostic and treatment services.

### **Patient Navigator Qualifications**

The qualifications for patient navigators include (but are not limited to):

- Positive relationship-building skills
- Effective oral and written communication skills
- Demonstrated ability to effect change
- Strong analytic skills
- Effective planning and organizational skills
- Ability to promote client and family autonomy
- Knowledge of funding resources and services
- Knowledge of clinical standards and outcomes

## **E. Policy and Protocol to Determine Place of Enrollment**

The client's county of residence determines the contracting region where he/she will be enrolled with the exception of American Indian clients who live on or near Montana reservations. American Indian men and women's county of residence the region that has direct responsibility for serving the reservation.

## **F. MCCP Support to Cancer Control Specialists**

### **1. Quality Assurance**

- Implement policies and systematic procedures designed to monitor and improve the MCCP.
  - Identify corrective actions to be taken to remedy any problems found in the quality of care provided to the MCCP target population.
- Ensure enrolled medical providers maintain a valid license to practice in Montana.
  - Mammography facilities must be fully certified by the Food and Drug Administration under the Mammography Quality Standards Act of 1992 (MQSA).
  - Cytology facilities must be fully certified by the Food and Drug Administration under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
- Review client screening data to monitor compliance with the MCCP eligibility guidelines.
- Review patient navigation data for compliance to timeliness and resources used.

### **2. Reimbursement**

The MCCP will:

- Reimburse enrolled medical service providers for the cost of performing covered services, provided these have been conducted in accordance with the algorithms approved by the MCCP. Clients are responsible for paying for any other services or tests.
- Reimburse all approved medical service providers for allowable claims according to the current approved fee schedule, within the time frames and under the guidelines outlined in the MCCP PPM (chapter 3).
- Ensure that Montana Medical Billing on behalf of the MCCP, will:
  - Receive all medical service provider enrollment packets and ensure all federal and state requirements are met for each provider.
  - Ensure medical service providers meet all insurance, licensure and certification requirements for program services as outlined in the MCCP PPM.
  - Receive and adjudicate all claims and reimbursement data, including review for third party payment, duplication, client eligibility and allowable services.

**Note:** The MCCP is the payer of last resort except for Indian Health Service. The MCCP will provide reimbursement for covered services only if no other source of payment is available to the client. Other available sources of payment include:

- Private insurance (whole or partial payment)
- Medicare
- Medicaid
- Title X Family Planning
- Other local private or public funded programs

This means reimbursement for screening services provided to men and women enrolled in Medicare Part B should be paid by Medicare, not by the MCCP. Medicare Part B is an optional program charging a monthly premium for enrollment. A person who cannot pay the premium to enroll in Medicare Part B and meets the MCCP income eligibility criteria is eligible to receive MCCP services.

### **3. Training and Communication**

MCCP will:

- Provide training, technical assistance and consultation necessary for the performance of services, including support from MCCP consultants on comprehensive cancer control, community collaboration, public outreach and medical service professional education and support.
- Be readily accessible to the Contractor to discuss program issues.
- Provide electronic access to regular reports to the Contractor, which includes a list of MCCP clients screened in the multi-county area and the status of clinical data as required in the MCCP PPM for these clients.
- Provide a toll-free fax line with which the Contractor may communicate with the program.
- Provide data collection forms, provider enrollment packets, MCCP PPMs updates, program brochures and education materials via [www.cancer.mt.gov](http://www.cancer.mt.gov) to the Contractor.
- Provide telephone and web meetings related to MCCP operations.
- Provide electronic access to the MCCP site data system as applicable for site entry of data collection forms.

**Eligibility Information**

What is your age?	Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
Family's yearly income before taxes	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of people in household	Insurance Company	

**Enrollment Information**

Last Name	First Name	Middle Initial	Other Last Names Used
Date of Birth MM / DD / YYYY	Social Security Number	State	County
Mailing Address	Street Address		City
Home/Cell Phone	Work/Message Phone		Zip

**Ethnic Background**

Are you Hispanic? (Spanish/ Hispanic / Latino)  
 Yes  No  Unknown

**Race:** Check all races that apply.

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

**Medical Background**

Are you having any breast problems?  Yes  No

Do you have breast implants?  Yes  No

Have you ever had a mammogram?  Yes  No

Date of last mammogram \_\_\_\_\_  
MM / DD / YYYY

Have you ever had a Pap test?  Yes  No

Date of last Pap \_\_\_\_\_  
MM / DD / YYYY

Have you ever had a hysterectomy?  Yes  No

**Do you use tobacco?** No  Yes  **If Yes, refer the client to the MT Quit Line. 1-800-QUIT-NOW**

How did you hear about the program? Please check all that apply.

- Radio
- Presentation
- Pink/Purple Card (Pamphlet)
- Special Promotion/Event/Ad
- TV
- Medical Provider
- Government Office
- Newspaper/Newsletter
- Internet
- MAIWHC
- Re-screen/Previously Enrolled
- Fair-Job/Health or Pow Wow
- Family/Friend/Word of Mouth
- \_\_\_\_\_

**PLEASE READ AND SIGN THE  
INFORMED CONSENT AND AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION**



Office Use Only Fiscal Yr \_\_\_\_\_ Admin Site # \_\_\_\_\_ State ID \_\_\_\_\_

**Form(s) submitted**  **New Screening Cycle**  **Re-submitted with revisions**

Eligibility determined by (please print) \_\_\_\_\_ Date MM / DD / YYYY

Client under age - prior approval given by \_\_\_\_\_ Date MM / DD / YYYY

Client under age (18-29) - meets criteria

**Client Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Informed Consent and Authorization to Disclose Health Care Information**

The Montana Cancer Control Programs (MCCP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana men and women can be screened through this program for colorectal cancer and women can also receive breast and cervical cancer screenings. Each time a client is screened for colorectal cancer, they may receive either an FOBT/FIT test or a colonoscopy. If any of the initial tests for colorectal cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic colonoscopy and/or biopsy of colon tissue. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

**Services Not Covered**

The MCCP only provides services for colorectal, breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

**Insurance Information**

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

**Confidentiality**

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

**Authorization to Disclose Health Care Information**

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), the laboratory reading my FIT and/or Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask questions about the MCCP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCCP at any time.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
MM / DD / YYYY

**Print Full Name:** \_\_\_\_\_



Client Name

Phone Number

State ID

Social Security Number

Date of Birth MM / DD / YYYY

Admin Site #

Revised

CERVICAL CANCER SCREEN RESULTS

Date of Pap test, Pap specimen type, Adequacy of Pap specimen, Result of screening Pap test, Date of HPV/DNA test, High Risk HPV/DNA test results if done, Paid by MCSP

Reason for Pap test, Date referred to the MCSP for diagnostic workup, Additional procedures, Next Pap test or follow-up due, Recommendations/comments, Provider's signature, Print provider's name

Respond for ALL clients screened for cervical cancer, Has this client had a hysterectomy?, Is the cervix still present?, A client who has had a hysterectomy is eligible for an MCSP Pap test if the hysterectomy was due to cervical neoplasia or the cervix is present.

Respond for clients with a NORMAL Pap test result, Recommend the cervical cancer screening interval for this client.

BREAST CANCER SCREEN RESULTS

Date of Clinical Breast Exam, Clinical Breast Exam (CBE) findings, Date of Mammogram, Mammogram type, Mammography test results - BI-RAD Categories, Paid by the MCSP

Reason for Mammography test, Date referred to the MCSP for diagnostic workup, Additional procedures, Next breast screening or follow-up due, Recommendations/comments, Provider's signature, Print provider's name



Breast and Cervical Abnormal Form

Client Name, Phone Number, State ID, Social Security Number, Date of Birth, Admin Site #, Revised checkbox

Additional Procedures table with columns: Additional Procedures, Date, Results, Diagnostics Paid by MCSP. Rows include imaging procedures, final imaging outcome, surgical consult, biopsy, colposcopy, etc.

Breast Final Diagnosis section with checkboxes for Cancer not diagnosed, Cancer, in-situ - LCIS, Cancer, in-situ - DCIS, Cancer, invasive

Cervical Final Diagnosis section with checkboxes for Normal/benign/inflammation, HPV/condylomata/Atypia, Mild dysplasia/CIN I, Low grade SIL, Moderate dysplasia/CIN II, High grade SIL, Severe dysplasia/CIN III/Carcinoma in situ, Invasive cervical carcinoma, Other - List

Complete for Breast and /or Cervical Findings

Status of final diagnosis/imaging: (date is required) with checkboxes for Workup complete, Workup refused, Lost to follow-up, Date fields, and Comments

Status of treatment: (required for bolded final diagnoses) with checkboxes for Started, Refused, Lost to follow-up, Date fields, Next screening or follow-up due, Provider's signature, Print provider's name



# Colorectal Eligibility & Enrollment Form



<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>	<b>Other Last Names Used (If Applicable)</b>	
<b>Birth Date</b> MM / DD / YYYY	<b>Age</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Social Security Number</b> - -		<b>State</b>	<b>County</b>
<b>Mailing Address</b>			<b>City</b>		<b>Zip</b>	
<b>Annual Family Income before Taxes</b>		<b>Number of People in Household</b>		<b>Home/Cell Phone</b>		<b>Work Phone</b>
<b>Do you have Medicare Part B?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you have Medicaid?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you have health insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Name of Insurance Company</b>		
<b>Ethnic Background</b> Are you Hispanic? (Spanish/ Hispanic / Latino) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<b>How did you hear about the program?</b> Please check all that apply.			
<b>Race:</b> Check all races that apply. <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian /Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black/African American			<input type="checkbox"/> Doctor <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> NBCCEDP/Colorectal Program <input type="checkbox"/> TV <input type="checkbox"/> Mailing Flyer <input type="checkbox"/> Magazine Article <input type="checkbox"/> Radio <input type="checkbox"/> Family Member <input type="checkbox"/> Community Event <input type="checkbox"/> Other _____			

\*\*\*\*\* To Be Completed By The Client With The Assistance of The Screening Specialist \*\*\*\*\*

**Do you use tobacco?** No  Yes  **If Yes, refer the client to the MT Quit Line. 1-800-QUIT-NOW**

## Screening History / Risk Assessment

### Colorectal Cancer Screening History:

Have you ever had a colorectal cancer screening test?  Yes  No  Unknown Date: \_\_\_\_\_  
(FOBT/FIT, Colonoscopy, Sigmoidoscopy, DCBE, CTC, Stool DNA)

### Personal History of Colorectal Cancer:

Have you ever been diagnosed with colorectal cancer?  Yes  No  Unknown  
Have you ever been diagnosed with polyps?  Yes  No  Unknown  
Have you ever been diagnosed with pre-cancerous polyps or adenomatous polyps?  Yes  No  Unknown

### Family History of Colorectal Cancer:

Has a blood relative been diagnosed with colorectal cancer or pre-cancerous polyps / adenomatous polyps?  Yes  No  Unknown

### Are you currently experiencing any of the following symptoms?

Yes  No  Unknown

#### Please check all that apply.

- Rectal bleeding, dark stool, blood in the stool within the past 6 months.
- Prolonged change in bowel habits: diarrhea/constipation for more than 2 weeks.
- Persistent abdominal pain.
- Symptoms of bowel obstruction, abdominal distension, nausea, vomiting.
- Significant unintentional weight loss of 10% or more of starting body weight.

### Have you been diagnosed with or are you being treated for any of the following?

Yes  No  Unknown

#### Please check all that apply.

- A genetic diagnosis of Familial Adenomatous Polyposis (FAP) or Hereditary Non Polyposis Colorectal Cancer (HNPCC)?
- A clinical diagnosis or suspicion of FAP or HNPCC?
- Inflammatory Bowel Disease ( Crohn's Disease or Ulcerative Colitis)?

**Did the client sign the Informed Consent Form?**  Yes  No

### Office Use Only

**Admin Site #** \_\_\_\_\_

**State ID** \_\_\_\_\_

**Eligibility Determined By:** \_\_\_\_\_

**Date Eligible** \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Informed Consent and Authorization to Disclose Health Care Information**

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I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask questions about the MCCP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCCP at any time.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
MM / DD / YYYY

**Print Full Name:** \_\_\_\_\_



# Colorectal Screening Form

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Birth Date</b> MM / DD / YYYY	<b>Admin Site #</b>
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<b>Social Security Number</b> - -	<b>Phone Number</b>	<b>State ID</b>
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<b>Date initial test scheduled or fecal kit distributed</b> Date MM / DD / YYYY	<b>Screening adherence</b> <input type="checkbox"/> Not done, FOBT/FIT kit not returned <input type="checkbox"/> Not done, appointment not kept.
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<b>Take Home Test :</b> <input type="checkbox"/> FOBT <input type="checkbox"/> FIT		<b>Take Home Test FOBT or FIT Section</b>	
<b>Date of result</b> MM / DD / YYYY	<b>Provider specialty</b>		
<b>Indication for test</b> <input type="checkbox"/> Screening	<input type="checkbox"/> General Practitioner	<input type="checkbox"/> Internist	<input type="checkbox"/> Family Practitioner
<b>Result</b>	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> General Surgeon	<input type="checkbox"/> Radiologist
<input type="checkbox"/> Negative	<input type="checkbox"/> Colorectal Surgeon	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> OB/Gyn
<input type="checkbox"/> Positive	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Pending	<b>Next test recommended in this cycle</b>		
<input type="checkbox"/> Unknown	<input type="checkbox"/> Complete	<input type="checkbox"/> Sigmoidoscopy	<input type="checkbox"/> Surgery to complete diagnosis
<b>Outcome</b>	<input type="checkbox"/> Incomplete/Inadequate	<input type="checkbox"/> DCBE	<input type="checkbox"/> None, cycle complete
If Incomplete/inadequate, reason: _____	<input type="checkbox"/> Other _____		

<b>Procedure Performed:</b> <input type="checkbox"/> Colonoscopy <input type="checkbox"/> DCBE		<b>Endoscopy Section I</b>	
<b>Procedure Date</b> MM / DD / YYYY	<b>Provider specialty</b>		
<b>Indication for test</b> <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnostic	<input type="checkbox"/> General Practitioner	<input type="checkbox"/> Internist	<input type="checkbox"/> Family Practitioner
<b>Result</b>	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> General Surgeon	<input type="checkbox"/> Radiologist
<input type="checkbox"/> Normal/negative/diverticulitis/hemorrhoids	<input type="checkbox"/> Colorectal Surgeon	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> OB/Gyn
<input type="checkbox"/> Other findings, not suggestive of cancer/polyps	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Polyps/suspicious for cancer/presumed cancer	<b>Adequate bowel preparation to detect polyps greater than 5mm.</b> (decided by the endoscopist) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Inadequate/Incomplete test with no findings	<b>Was the cecum reached during this colonoscopy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Pending	<b>If No, was the splenic flexure reached?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Outcome</b>	<b>Were there any complications?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Complete <input type="checkbox"/> Incomplete/Inadequate	<b>If Yes, complete the Colorectal Endoscopy Section II Form.</b>		
<b>Was a biopsy/polypectomy performed during the endoscopy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Next test recommended in this cycle</b>		
<b>If Yes, complete the Colorectal Endoscopy Section II Form.</b>	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Sigmoidoscopy	<input type="checkbox"/> Surgery to complete diagnosis
	<input type="checkbox"/> DCBE	<input type="checkbox"/> None, cycle complete	<input type="checkbox"/> Other _____

<b>Status of Final Diagnosis</b> <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Refused diagnostic follow-up <input type="checkbox"/> Lost to follow-up before final diagnosis	<b>Final Diagnosis</b> <input type="checkbox"/> Normal/Negative <input type="checkbox"/> Hyperplastic polyps <input type="checkbox"/> Adenomatous polyp, no high grade dysplasia <input type="checkbox"/> Adenomatous polyp, with high grade dysplasia <input type="checkbox"/> Cancer	<b>Recurrent Cancers</b> <input type="checkbox"/> New colorectal cancer, primary <input type="checkbox"/> Recurrent colorectal cancer <input type="checkbox"/> Non colorectal cancer primary (metastasis from another organ) <input type="checkbox"/> Unknown
<b>Date of final diagnosis, refused, or lost to follow up</b> MM / DD / YYYY		

<b>Recommended screening or surveillance test for next cycle</b> <input type="checkbox"/> Take home FOBT <input type="checkbox"/> Take home FIT <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> DCBE <input type="checkbox"/> None	<b>Number of months before screening or surveillance test for next cycle.</b> (If none, leave blank) _____
	<b>Indication for screening or surveillance test for next cycle</b> <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance after a positive colonoscopy and/or surgery

**If client has a polypectomy, biopsy, surgery or complications, complete the Colorectal Endoscopy Section II Form.**

<b>Provider Signature</b> _____	<b>Provider Name</b> _____
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<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Birth Date</b> MM / DD / YYYY	<b>Admin Site #</b>
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<b>Social Security Number</b> - -	<b>Phone Number</b>	<b>State ID</b>
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<p><b>Histology of most severe polyp/lesion</b> (Complete if biopsy/polypectomy was done during the colonoscopy)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Normal or other non-polyp histology</li> <li><input type="checkbox"/> Non-adenomatous polyp (inflammatory, hamartomatous, etc.)</li> <li><input type="checkbox"/> Hyperplastic polyp</li> <li><input type="checkbox"/> Adenoma, NOS (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, tubular (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, mixed tubular villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, serrated (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma with high grade dysplasia (includes in situ carcinoma)</li> <li><input type="checkbox"/> Adenocarcinoma, invasive</li> <li><input type="checkbox"/> Cancer, other</li> <li><input type="checkbox"/> Unknown/other lesions ablated, not retrieved or confirmed</li> </ul> <p><b>Number of adenomatous polyps/lesions</b> (Complete if result of the histology is Adenoma or Cancer)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than 97.....Enter the number _____</li> <li><input type="checkbox"/> 97 or more adenomatous polyps/lesions</li> <li><input type="checkbox"/> At least one adenomatous polyps/lesions, exact number not known</li> <li><input type="checkbox"/> Unknown</li> </ul> <p><b>Size of largest adenomatous polyp/lesion</b> (Complete if result of the histology is Adenoma or Cancer)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than 1 cm..... Enter the size _____</li> <li><input type="checkbox"/> Greater than 1 cm ...Enter the size _____</li> <li><input type="checkbox"/> Between 1 cm and 2 cm    <input type="checkbox"/> Between 2 cm and 3 cm</li> <li><input type="checkbox"/> Between 3 cm and 4 cm    <input type="checkbox"/> Between 4 cm and 5 cm</li> <li><input type="checkbox"/> Microscopic focus        <input type="checkbox"/> Diffuse</li> <li><input type="checkbox"/> Unknown (size not stated)</li> </ul>	<p><b>Histology from surgical resection</b> (Complete if surgery was performed to complete diagnosis.)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Surgery recommended but not performed</li> <li><input type="checkbox"/> Normal or other non-polyp histology</li> <li><input type="checkbox"/> Non-adenomatous polyp (inflammatory, hamartomatous, etc.)</li> <li><input type="checkbox"/> Hyperplastic polyp</li> <li><input type="checkbox"/> Adenoma, NOS (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, tubular (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, mixed tubular villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, villous (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma, serrated (no high grade dysplasia noted)</li> <li><input type="checkbox"/> Adenoma with high grade dysplasia (includes in situ carcinoma)</li> <li><input type="checkbox"/> Adenocarcinoma, invasive</li> <li><input type="checkbox"/> Cancer, other</li> <li><input type="checkbox"/> Unknown/other lesions ablated, not retrieved or confirmed</li> </ul> <p><b>Date surgery performed</b>    MM / DD / YYYY</p> <p><b>Complications of endoscopy requiring observation or treatment.</b> (Report the worst of up to 2 serious complications of CRC testing occurring within 30 days of the test date and resulting in an ER visit or hospitalization.)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No complications</li> <li><input type="checkbox"/> Bleeding, transfusion required</li> <li><input type="checkbox"/> Bleeding not requiring transfusion</li> <li><input type="checkbox"/> Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc)</li> <li><input type="checkbox"/> Complications related to anesthesia</li> <li><input type="checkbox"/> Bowel perforation</li> <li><input type="checkbox"/> Post-polypectomy syndrome/excessive abdominal pain</li> <li><input type="checkbox"/> Death</li> <li><input type="checkbox"/> Other _____</li> </ul>
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<p><b>Print Provider's Name</b> _____</p> <p><b>Provider's Signature</b> _____</p>	<p><b>Status of treatment (Complete if final diagnosis is Cancer)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Started and/or completed</li> <li><input type="checkbox"/> Not indicated due to polypectomy</li> <li><input type="checkbox"/> Not recommended</li> <li><input type="checkbox"/> Refused</li> <li><input type="checkbox"/> Lost to follow-up</li> <li><input type="checkbox"/> Treatment pending</li> </ul> <p><b>Date of treatment</b>    MM / DD / YYYY</p>
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Date Initiated \_\_\_\_\_ Regional Site \_\_\_\_\_

Patient Navigator \_\_\_\_\_

Last Name:		First Name:		Social Security Number:	
BREAST FOLLOW-UP					
Procedure Scheduled < 60 days of abnormal finding	Provider Name	Appointment Date	Appointment Re-Scheduled	Results	Completion Date/Initial
<input type="checkbox"/> Diagnostic Mammogram					
<input type="checkbox"/> Breast Ultrasound					
<input type="checkbox"/> Surgical Consult/Repeat Breast Exam					
<input type="checkbox"/> Fine Needle Biopsy/Cyst Aspiration					
<input type="checkbox"/> Biopsy					
<input type="checkbox"/> Other (specify): _____					
CERVICAL FOLLOW-UP					
Procedure Scheduled < 60 days of abnormal finding	Provider Name	Appointment Date	Appointment Re-Scheduled	Results	Completion Date/Initial
<input type="checkbox"/> GYN Consult					
<input type="checkbox"/> Colposcopy with Directed Biopsy,ECC					
<input type="checkbox"/> Other (specify): _____					

**Monitoring Dates:**

Weekly, until date of final diagnosis or application for Medicaid treatment is made (if needed) and treatment initiated

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**Lost to follow-up/Refusal: Contact Attempts**

Contact Method	Date	Result
<input type="checkbox"/> Telephone	_____	_____
<input type="checkbox"/> Telephone	_____	_____
<input type="checkbox"/> Telephone	_____	_____
<input type="checkbox"/> Letter	_____	_____
<input type="checkbox"/> Certified Letter	_____	_____

**Montana Cancer Control Programs**  
**Acknowledgment of Refusal to Consent to Diagnostic Tests or Treatment**

**Patient Name (Print):** \_\_\_\_\_

My health care provider has recommended further diagnostic testing/treatment to me. I understand these diagnostic tests will help my health care provider diagnose cancer or the treatment recommended for cancer.

I have read and understand the paragraph(s) below that pertain to my decision to refuse diagnostic tests and/or treatment.

The health care provider named below has explained to me that I need **diagnostic test(s)** to determine if I have breast, cervical, or colorectal cancer (circle one). The test(s) that are recommended to me include:

\_\_\_\_\_

If the diagnostic test(s) have been completed, I have read and understand the result(s) and the diagnoses that are listed below:

\_\_\_\_\_

The health care provider named below has explained to me that I need **treatment** for breast, cervical or colorectal cancer (circle one). The treatment recommended to me is:

\_\_\_\_\_

My health care provider named below has explained to me that the recommended test(s)/treatment are for breast, cervical or colorectal (circle one) cancer and the likely consequences of refusing the test(s) or treatment, if I have cancer are:

\_\_\_\_\_

I understand that the refusal of the test(s)/ treatment recommended by my health care provider may endanger my health, or could lead to my death. Knowing this, I refuse to consent to such recommended test(s)/treatment.

I hereby release my doctor/health care provider, \_\_\_\_\_(Print Name)  
and the Montana Department of Health and Human Services (DPHHS) from any liability or responsibility for not providing the test(s)/treatment described and referred to above.

\_\_\_\_\_(Date)\_\_\_\_\_  
Patient signature

\_\_\_\_\_(Date)\_\_\_\_\_