



MCCP Breast and Cervical  
Cancer Screening Form



**Contact information:**

Client name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_ SSN: \_\_\_\_\_  
 MCCP Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Additional Procedures	Date	Results
<b>Imaging Procedures</b>		<b>Results of Imaging Procedure</b>
• Additional mammographic views _____	_____	<input type="checkbox"/> Done _____
• Ultrasound _____	_____	<input type="checkbox"/> Done _____
• Film comparison _____	_____	<input type="checkbox"/> Done _____
• Other; list: _____	_____	<input type="checkbox"/> Done _____
Surgical consult, repeat breast exam _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Fine needle biopsy/cyst aspiration _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Incisional biopsy _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Excisional biopsy _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Colposcopy directed biopsy/ECC _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Diagnostic LEEP _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Diagnostic cold knife cone _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Diagnostic endocervical curettage _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Gyn consult _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
Other; list: _____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
<b>Breast Final Diagnosis</b>		<b>Cervical Final Diagnosis</b>
<input type="checkbox"/> Cancer not diagnosed		<input type="checkbox"/> Normal/benign/inflammation
<input type="checkbox"/> Cancer, in-situ - LCIS		<input type="checkbox"/> HPV/Condylomata/Atypia
<input type="checkbox"/> <b>Cancer, in-situ - DCIS **</b>		<input type="checkbox"/> Mild dysplasia/CIN I (bx dx)
<input type="checkbox"/> <b>Cancer, invasive **</b>		<input type="checkbox"/> Mild dysplasia/CIN I (bx dx)
		<input type="checkbox"/> <b>Moderate dysplasia/CIN II (bx dx) **</b>
		<input type="checkbox"/> <b>High Grade SIL (bx dx) **</b>
		<input type="checkbox"/> <b>Severe dysplasia/CIN III/Carcinoma in situ **</b>
		<b>(Adenocarcinoma in situ of the cervix (bx dx))</b>
		<input type="checkbox"/> <b>Invasive Cervical Carcinoma (bx dx) **</b>
		Other; list: _____

**Complete for Breast and/or Cervical Findings**

<b>Status of final diagnosis/imaging (date is required)</b> <input type="checkbox"/> Work-Up complete Date _____ <input type="checkbox"/> Work-Up refused Date _____ <input type="checkbox"/> Lost to Follow-Up Date _____	<b>** Status of treatment (required for bolded final diagnosis)</b> <input type="checkbox"/> Started Date _____ <input type="checkbox"/> Refused Date _____ <input type="checkbox"/> Lost to Follow-Up Date _____ Next Screening or Follow-Up Date _____
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**Recommendations/comments:**

**Provider's Signature:** \_\_\_\_\_ **Print provider's name:** \_\_\_\_\_