University of Puerto Rico Comprehensive Cancer Center
Puerto Rico Breast and Cervical Cancer Prevention and Early Detection Program
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Cervical Cancer Screening Data Collection Form

(Follow Cancer Screening Guidelines provided)

Program Use Only

Patient ID: _____

Cycle #: ___

A. Patient Information

1a. Last Names	1b. First Name	1c. Initial	2. SSN	3. DOB	4. Age

5a. Postal Address	5b. Municipality	5c. State	5d. Zip Code	6. Phone Number

7. Provider #	8. Record #	9. Municipality of Screening

B. Cervical Screening History

10a. Has the patient had a **prior** Pap Test? **If Yes,**	◯Yes ◯No ◯Unknown	12a. Has the patient received an HPV vaccination? **If Yes,**	◯Yes ◯No ◯Unknown
10b. Date of **prior (last)** Pap test:		15b. Date of **first** HPV vaccination:	
11. Is there history of the following conditions? (Mark all that apply)		15c. Number of doses received:	◯1 ◯2 ◯3
11a. Dysplasia/cervical cancer	◯Yes ◯No ◯Unknown		
11b. HPV	◯Yes ◯No ◯Unknown	13. Is the patient post-menopausal?	◯Yes ◯No ◯Unknown
11c. HIV	◯Yes ◯No ◯Unknown	14. Is the patient pregnant?	◯Yes ◯No ◯Unknown
11d. Immune-compromised	◯Yes ◯No ◯Unknown	15a. Has the patient had a hysterectomy? **If Yes,**	◯Yes ◯No ◯Unknown
		15b. Was the hysterectomy performed for either **cervical cancer or Neoplasia**?	◯Yes ◯No ◯Unknown

C. Cervical Screening Tests

16. **Test(s) Requested (Mark all that apply):** **Date of test(s)**

☐ **Pelvic exam:**	
☐ **Pap test:**	
☐ **HPV test:**	

17. **Pelvic exam results:**

◯Normal ◯Abnormal pelvic
◯Abnormal-not suspicious for cancer
◯Abnormal-suspicious for cancer
◯Other result (Specify):

18a. **Indication for Pap test to be performed on this screening:**

◯Routine Pap Test
◯Patient under surveillance for a previous abnormal test
◯Already done by a non-program provider, patient referred in for diagnostic evaluation

18b. **Date of referral:**

◯Not done, Patient proceeded directly for diagnostic work-up or HPV test
◯Not done, Breast record only

19. **Type of Pap Test (Specimen Type):**

◯Conventional Smear ◯Liquid Based
◯Other ◯Unknown

20. **Specimen Adequacy:**

◯Satisfactory ◯Unsatisfactory ◯Unknown

21. **Pap Test results:**

◯Negative ◯ASC-US
◯LSIL ◯HSIL
◯ASC-H ◯Squamous Cell Carcinoma
◯AGC ◯Adenocarcinoma
◯AIS ◯Result unknown, presumed abnormal Pap done by a non-program provider
◯Other result (Specify):

22. **HPV Test Result:** (If positive, specify type)

◯Positive: ◯LR ◯HR ◯Unknown
◯Negative
◯Unknown
◯Not done

23. **Diagnostic Work-up Plan:**

◯Planned ◯Not Planned

24a. **Follow up:**

◯Short term 24b. **Specify Short-Term months**

◯Pap in 1 year
◯Pap in 3 years
◯Pap in 5 years
◯**Additional Diagnostic Procedures (Complete the Cervical Cancer Diagnosis Data Collection Form):**

☐Gynecologic Consultation
☐Colposcopy w/o Biopsy
☐Colposcopy with Biopsy
☐Colposcopy with ECC
☐ECC (Only) ☐LEEP ☐CKC
☐Laser Conization
☐Other biopsy-not colposcopy
☐Other procedure (Specify):

25. **Bill to PRBCCEDP**:	◯Yes ◯No	26. **Comments:**	

27. **Provider's Name and Signature:**	28. **Date:**