

SCREENING INTAKE FORM - BILLING FORM
New York State Cancer Services Program

Intake Site

Intake Date **20**
 Mo. Day Yr.

PLEASE PRINT CLIENT INFORMATION

1. Name Last First MI MR#

2. Client No.

3. Birth Date **19**
 Mo. Day Yr.

4. Mailing Address Maiden Name

5. City State

6. Zip 7. Area Code Telephone Number

8. Social Security Number

9. Sex 1. Male 2. Female

10. Name and number of someone to call if we can't reach you. Name Phone Relationship

11. Are you Spanish, Hispanic or Latino? 1. Yes 2. No 3. Unknown

12. Race (check all that identify your race).
 1. White 4. American Indian or Alaska Native
 2. Black or African American 6. Unknown
 3. Asian 7. Native Hawaiian or other Pacific Islander

13. Country of Birth

14. County of Residence

15. How Heard of Program (can check more than one)
 01. Reminder received 05. Word of mouth
 02. Education/outreach 06. Pamphlet/brochure
 03. Advertising 07. Other
 04. Clinic or doctor 08. Recalled by CSP

16. Monthly Household Income

17. Family Size

18. Health Insurance (can check more than one unless client is uninsured)
 1. Uninsured
 2. Medicaid A. Monthly spend down Monthly Spend Down Amount (\$)
 3. Medicare A. Part A only B. Parts A and B
 4. Private Policy No. A. Services not covered B. High deductible - annual high deductible amount (\$)
 5. Title X Family Planning/FPBP

CANCER SCREENING HISTORY

19a. Previous Mammogram 1. Yes 2. No 3. Unknown Where: Mo. Yr.

19b. Previous Clinical Breast Exam (CBE) 1. Yes 2. No 3. Unknown Where: Mo. Yr.

20. Previous Pap Test 1. Yes 2. No 3. Unknown Where: Mo. Yr.

21. Previous guaiac Fecal Occult Blood Test (gFOBT) 1. Yes 2. No 3. Unknown Where: Mo. Yr.

22. Previous Fecal Immunochemical Test (FIT) 1. Yes 2. No 3. Unknown Where: Mo. Yr.

23. Previous Sigmoidoscopy, DCBE or other CRC screening 1. Yes 2. No 3. Unknown Where: Mo. Yr.

24. Previous Colonoscopy 1. Yes 2. No 3. Unknown Where: Mo. Yr.

RISK STATUS

25a. Breast Cancer High Risk Criteria (Check all that apply)
 NOTE: For reimbursement of services for clients under 40, see Q25b or Q25c.
 1. Personal/family Hx of breast cancer - first degree
 2. Multi 2nd degree relatives w/breast or ovarian cancer
 3. Personal Hx of atypical ductal hyperplasia (ADH)
 4. BRCA 1 and/or BRCA 2 gene mutation
 5. None

25b. Client is at High Risk for Breast Cancer

25c. Clinically Significant Findings for Breast Cancer

26. Colorectal Cancer Increased Risk Criteria (Ineligible for Kit, refer to colonoscopy) (Check all that apply)
 1. Personal Hx of single small (<1cm) pre-cancerous polyp
 2. Personal Hx of large (1cm+), multiple, or pre-cancerous polyp with dysplasia or villous changes
 3. Personal Hx of colorectal cancer
 4. Colorectal cancer or pre-cancerous polyps in one first degree relative before age 60 or 2+ first degree relatives at any age
 5. None Age of Youngest Relative

27a. Colorectal Cancer High Risk Criteria (Ineligible for Kit, refer to colonoscopy) (Check all that apply)
 1. Family Hx of familial adenomatous polyposis (FAP)
 2. Family Hx of hereditary non-polyposis colon cancer (HNPCC)
 3. Personal Hx of Inflammatory bowel disease
 4. Personal Hx of Chronic ulcerative colitis
 5. Personal Hx of Crohn's disease
 6. None

27b. Immediate Colorectal Cancer Follow-up not required
 Future CRC Screening Date: Mo. Yr.

28. Symptomatic for Colorectal Cancer, for clients aged 50 to 64 only. (Ineligible for kit, refer for a colonoscopy)
 1. Yes 2. No
 If yes, symptoms (select one): 1. Abdominal mass
 2. Rectal (not pelvic) mass
 3. Prolonged rectal bleeding w/bowel change
 4. Persistent rectal bleeding no anal symptom
 5. Nonspecific symptom strongly suggest CRC

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Client Name _____

Client No. _____

MR# _____

Birth Date _____

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BREAST CANCER SCREENING SERVICES

29. Clinical Breast Exam Date Mo. Day Yr. 2 0	34. Mammogram Date Mo. Day Yr. 2 0	38. Type of Mammogram (check one box only) <input type="checkbox"/> 1. Bilateral screening mammogram <input type="checkbox"/> 2. Bilateral diagnostic mammogram <input type="checkbox"/> 3. Unilateral screening/diagnostic mammogram
31. CBE Site _____	36. Mammogram Site _____	
32. CBE Funds <input type="checkbox"/> 1. Program <input type="checkbox"/> 2. Other	37. Mammogram Funds <input type="checkbox"/> 1. Program <input type="checkbox"/> 2. Other	
33a. Self Reported Breast Symptoms <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unknown	33b. Breast Findings (Check one box only) <input type="checkbox"/> 1. Normal, benign, fibrocystic-rescreen in 1-2 years <input type="checkbox"/> 2. Probably benign-repeat exam in 3-6 months - submit new SIF <input type="checkbox"/> 3. Mass or other findings - immediate testing - submit follow up form <input type="checkbox"/> 5. Not indicated - CBE in past 12 months <input type="checkbox"/> 6. Indicated but not performed	39. Mammogram Results (check one box only) <input type="checkbox"/> BIRADS 1 - Negative <input type="checkbox"/> BIRADS 2 - Benign Finding <input type="checkbox"/> BIRADS 3 - Probably Benign, short term follow-up <input type="checkbox"/> BIRADS 4 - Suspicious abnormality, biopsy should be considered <input type="checkbox"/> BIRADS 5 - Highly suggestive of malignancy <input type="checkbox"/> BIRADS 0 - Need additional imaging <input type="checkbox"/> BIRADS 0 - Need prior mammogram for comparison <input type="checkbox"/> Not Indicated <input type="checkbox"/> Indicated but not performed
		40. Recommended Dates of Next Exam if NOT Immediate CBE 2 0 Mammogram 2 0 Mo. Day Yr.
		41. IMMEDIATE Breast Cancer Screening follow up (indicated if 3 checked in Q. 33b or BIRADS 4, 5 or 0 checked in Q. 39) Date Referred 2 0 Mo. Day Yr. Provider Referred To _____ COMPLETE BREAST FOLLOW UP FORM

CERVICAL CANCER SERVICES

42a. Referral for Cervical Screening <input type="checkbox"/> 1. Yes <input type="checkbox"/> 3. Not indicated - cervical screening in past 12 months <input type="checkbox"/> 4. Refused <input type="checkbox"/> 5. Not indicated - hysterectomy with cervix removed <input type="checkbox"/> 6. Not indicated - per cervical screening guidelines <input type="checkbox"/> 7. Not indicated - short term colposcopy (leave Q42b through Q54 blank)	47. Pelvic Funds <input type="checkbox"/> 1. Program <input type="checkbox"/> 2. Other 48. Pap Funds <input type="checkbox"/> 1. Program <input type="checkbox"/> 2. Other	51. Pap Test Results (check one box only) <input type="checkbox"/> 01. Negative (within normal limits, includes infection) <input type="checkbox"/> 03. A.S.C.-U.S. <input type="checkbox"/> 04. Low grade SIL (including HPV changes) <input type="checkbox"/> 05. High grade SIL <input type="checkbox"/> 06. Squamous cell cancer <input type="checkbox"/> 07. Other _____ <input type="checkbox"/> 08. A.S.C.-H. Specify _____ <input type="checkbox"/> 09. Not indicated <input type="checkbox"/> 10. Indicated but not performed <input type="checkbox"/> 11. Pap attempted, no cervix <input type="checkbox"/> 12. A.G.C. - all subcategories
42b. <input type="checkbox"/> Clinical Exception to Cervical Screening Interval	49. Pelvic Exam Findings <input type="checkbox"/> 1. Suspicious for cervical cancer <input type="checkbox"/> 2. No findings related to cervical cancer <input type="checkbox"/> 4. Not done - repeating Pap	
43. Date of pelvic with Pap test Mo. Day Yr. 2 0	50. Pap Test Specimen Adequacy <input type="checkbox"/> 1. Satisfactory <input type="checkbox"/> 3. Unsatisfactory for evaluation Specify _____ <input type="checkbox"/> 4. Unsatisfactory specimen not processed Specify _____	
46. Pelvic Site _____	52. Pap Lab Site _____	55. IMMEDIATE Cervical Cancer Screening follow up (indicated if 7 checked in Q. 42a, 1 checked in Q. 49 or 4, 5, 6, 8 or 12 checked in Q. 51. Optional if 3 or 7 checked in Q. 51 or 2 checked in Q. 60.) Date Referred 2 0 Mo. Day Yr. Provider Referred To _____ COMPLETE CERVICAL FOLLOW UP FORM
53. Pap Specimen Type <input type="checkbox"/> 1. Conventional <input type="checkbox"/> 2. Liquid based	54. Recommended Date of Next Exam if NOT Immediate 2 0 Mo. Yr.	

HIGH RISK HPV DNA TESTING

56. Date of HR HPV Test Mo. Day Yr. 2 0	58. HR HPV Test Funds <input type="checkbox"/> 1. Program <input type="checkbox"/> 2. Other	60. HR HPV Test Findings <input type="checkbox"/> 1. Not Detected <input type="checkbox"/> 2. Detected <input type="checkbox"/> 3. Indeterminate
57. HR HPV Lab Site _____	59. Type of HR HPV Test <input type="checkbox"/> 1. Screening <input type="checkbox"/> 2. Surveillance	

BCC Notes:

COLORECTAL CANCER SCREENING SERVICES

64a. Kit Type <input type="checkbox"/> gFOBT <input type="checkbox"/> FIT PCP or Ordering Physician _____ Fax _____	65. FIT Kit ID (Optional) _____	70. Kit results <input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Inadequate/Incomplete
64b. Kit Distribution Date Mo. Day Yr. 2 0	66. Kit Status <input type="checkbox"/> 1. Returned (go to 67) <input type="checkbox"/> 2. Lost to follow-up (Stop Here) <input type="checkbox"/> 3. Refused to Return (Stop Here)	71. IMMEDIATE Colorectal Cancer Screening follow up (indicated if Q. 26 or Q. 27a checked, if 1 checked in Q. 28, 1 checked in Q. 70 or Q. 72 checked) Date Referred 2 0 Mo. Day Yr. Provider Referred To _____ COMPLETE COLORECTAL FOLLOW UP FORM
64c. Site of Kit Distribution _____	67. Kit Development Site _____	
64d. Provider Speciality _____	68. Kit Funds <input type="checkbox"/> 1. Program <input type="checkbox"/> 2. Other	
	69. Date Kit Developed Mo. Day Yr. 2 0	72. HHC Average Risk Colonoscopy (if checked, enter date in Q. 71) <input type="checkbox"/>

CRC Notes: