MISSISSIPPI BREAST AND CERVICAL CANCER PROGRAM (MSBCCP)
570 East Woodrow Wilson • Post Office Box 1700 • Jackson, Mississippi 39214-1700 • 601-576-7466

Cervical Follow-Up Referral

Referral Date_____/_____/_____ Enrollment Site _____
mm dd yyyy Referring Provider_____

Patient's Name_____
Last First Middle Initial Maiden

Phone Number (Day)_____ Phone Number (Night)_____

Address_____
Number and Street City State Zip

Date of Birth_____/_____/_____ Social Security Number_____
mm dd yyyy

Reason for Referral_____

Referred to (Clinic/Physician) _____ Phone Number_____

Appointment Date _____/_____/_____
mm dd yyyy

Please send a copy of this form and report to the MSBCCP address listed above or fax a copy to (601) 576-8030.

Physician Instructions: Please Check (√) All That Apply

Repeat Pap/Gynecological Consult

- ☐ Negative for Intra lesion or malignancy
- ☐ Infection/Inflammation Reactive Changes
- ☐ ASC-US
- ☐ ASC-H*
- ☐ High-Grade SIL*
- ☐ Low-Grade SIL
- ☐ Squamous cell Carcinoma *
- ☐ Atypical glandular Cells (AGC)*
- ☐ Adenocarcinoma in-situ(AIS)*
- ☐ Adenocarcinoma*
- ☐ Other_____
- ☐ Unsatisfactory (repeat pap)
- ☐ Result Pending
- ☐ Unknown (Presumed abnormal)
- ☐ Not Done/Refused

HPV Test Result:

- ☐ Positive with genotyping not done/Unknown
- ☐ Negative
- ☐ Positive with positive genotyping
- ☐ Positive with negative genotyping
- ☐ Unknown

Diagnostic Work-up (Please Check (√) Services Provided)

Date performed _____/_____/_____
mm dd yyyy

- ☐ CPT_____ Cold Knife Cone(CKC)
- ☐ CPT_____ Colposcopy Without Biopsy
- ☐ CPT_____ Colposcopy w/Biopsy and/or ECC
- ☐ CPT_____ Endocervical Curettage Alone
- ☐ CPT_____ LEEP\LEETZ
- ☐ CPT_____ Other Procedures Performed

Status of Final Diagnosis

- ☐ Work-up Complete
- ☐ Work-up Pending
- ☐ Lost to Follow-up
- ☐ Work-up Refused

Final Diagnosis Date of Final Diagnosis ____/____/____
mm dd yyyy

- ☐ Normal/Benign reaction/inflammation
- ☐ HPV/ Condylomata /Atypia
- ☐ CINI/Mild Dysplasia (biopsy diagnosis)
- ☐ CINII/Moderate Dysplasia (biopsy diagnosis) *
- ☐ CINIII/Severe Dysplasia/CIS *
- ☐ Invasive Cervical Carcinoma *
- ☐ Other_____

***Please contact primary provider as soon as a diagnosis of cancer is known. Upon diagnosis, enrolled patient will be referred to Medicaid. The pathology report must be submitted to MSBCCEDP for Medicaid referral.**

Date of Diagnosis _____/_____/_____
mm dd yyyy

Treatment Status*

☐ Treatment started, date_____/_____/_____
mm dd yyyy

***MSBCCP does not pay for treatment; however, the program will refer patients to the Mississippi Division of Medicaid for financial assistance.**

_____ _____ _____/_____/_____
Physician's signature License Number mm dd yyyy

Mississippi Breast and Cervical Cancer Early Detection Program

CERVICAL FOLLOW - UP REFFERAL FORM
FORM #691

PURPOSE

The purpose of this form is to provide written documentation for patients requiring follow-up of abnormal Pap tests and for whom a referral is made to a gynecologist.

INSTRUCTIONS

This form is to be completed on all women screened through the Mississippi Breast and Cervical Cancer Early Detection Program requiring a referral for suspicious findings.

Referral Date: Enter today's date using two-digit month, two-digit day and four-digit year.
Enrollment Site: Enter the site where the patient is being seen today by provider.
Referring Provider: Enter the provider's name who is sending the patient for procedure or test.

Patient Information Section: Must be completed in its entirety.
Patient's Name: Enter the last name, first name, middle and maiden if applicable.
Phone Number: Enter the daytime number and alternate number.
Address: Enter the number and street, city, state and zip of where the patient is living when she presents to the facility.
Date of Birth: Enter patient's date of birth using two-digit month, two-digit day and four-digit month.
Social Security Number: Enter nine-digit number. If patient does not have SSN, enter 000-00-000 in this area. **DO NOT LEAVE BLANK.**
Reason for Referral: Enter the reason the patient is being referred to outside provider/facility.
Referred to (Clinic/Physician): Enter the name of the clinic/site or the referral provider.
Phone Number: Enter the telephone number of the clinic/referral provider.
Appointment Date: Enter the patient's appointment with the referral provider using two-digit month, two-digit day and four-digit year.
The referral physician ONLY should complete the remainder of the form.

OFFICE MECHANICS AND FILING

The original form must be placed in the patient's record; a copy mailed or faxed to the referral provider; and a copy sent to the MS Breast and Cervical Cancer program.

RETENTION PERIOD

Retain according to agency policy for this type of patient retention schedule.

NOTE: Upon cancer diagnosis, the enrolled patient will be referred to The Division of Medicaid. The pathology report must be submitted to MSBCCEDP for Medicaid referral. MSBCCEDP does not pay for treatment; however, the patient may be referred for financial assistance through the Mississippi Division of Medicaid.