

Instructions Take Charge! Breast and Cervical Cancer Screening Form

ODH Form No. 274A

Please complete the entire form. ***Failure to provide complete information will delay reimbursement.***

General and Billing Instructions: The Breast and Cervical Cancer Screening form is completed at your facility. This form is used to provide clinical data and billing information. Failure to complete the form in its entirety will delay reimbursement. The form is a **three (3) page form**. Please make sure that you are submitting all pages of the form. The original of the three page form must be kept at your facility in the client's chart or scanned into their electronic health record. The original record must be retained at your facility for seven years. **A copy of the three-page form should be uploaded to the Take Charge! Program within 60 days from the date of the client's initial procedure**. Refer to your contract for additional information for supplying your paperwork to the Take Charge! Program.

-Please write neatly on the form using black ink.-

Part 1	Demographics
Chart ID#	This is for your office use. Write the chart ID# per your office instructions.
Facility name	Write your facility name.
Facility site number	Write the four digit number that is assigned to your facility.
Social security number	Write the client's social security number. If the client does not have a social security number, write "999-99-9999".
Age	Write the client's age on the date of the visit.
Last name	Ask the client to spell their last name and then write the information on the line.
First name	Ask the client to spell their first name and then write the information on the line.
MI	Ask the client their middle initial and then write the information on the line.
Maiden	Ask the client to spell their maiden name (if applicable) and then write the information on the line.
DOB	Write the client's date of birth in MM/DD/YYYY format.
Daytime phone number	Write the client's daytime phone number, including the area code.
Address, city, state, zip, county	Write the client's mailing address, city, state, zip code, and county. If the client does not have a mailing address, please enter a finding address (friend's address, significant other's address, etc..) contact information, and notate that it is a finding address.
Race	Ask the client their race. Mark one or more of the client's self-reported race.
Ethnicity	Mark the client's self-reported ethnicity.
Part 2	Referral Source
Referral Source	Mark the client's source of referral to the Take Charge! Program. Choose one only.
Part 3	Risk for Breast Cancer
Risk for Breast Cancer	Indicate if the client has risk of breast cancer.
Part 4	Breast Cancer Screening Information
Client Reports Breast Symptoms?	Mark the client's self-reported breast symptoms. If "yes", mark the type of symptom from list of options.
Prior Mammogram	Mark whether or not the client has received a mammogram in the past.
Location	Enter the location where the previous mammogram was provided. If unknown write "unknown".
Date	Enter the date of the previous mammogram in MM/DD/YYYY format.

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Part 5A	Indication For Initial Mammogram
Indication for initial mammogram	Mark the reason for receiving initial mammogram.
Part 5B	Clinical Breast Exam (CBE) Information
Facility name	Enter the facility where the CBE was provided.
Date of CBE performed	Write the date of CBE in MM/DD/YYYY format.
Paid by Take Charge! Program?	Mark if procedure was paid for by Take Charge! Program.
Findings of CBE	Mark the findings of the examination. Work-up is required if a bold option is chosen.
Clinical comments	This section is an aid for the clinician. Please note that these comments are not entered in database.
Part 5C	Breast Imaging/Mammogram
Referred For Mammogram	Mark if the client was referred for a screening or diagnostic mammogram.
Screening Mammography Referral Date	Write the date the client was referred for the mammogram in MM/DD/YYYY format.
Paid by Take Charge! Program?	Mark if procedure was paid for by Take Charge! Program. Mark "Yes" if a Coupon was issued to a Take Charge! contractor.
Facility Name	Enter the location where the mammogram was provided.
Date Performed	Write the date of mammogram in MM/DD/YYYY format.
Date Results Received	Write the date the provider received results in MM/DD/YYYY format.
Date Client Notified	Write the date client was notified of the results in MM/DD/YYYY format.
Date of Diagnostic Mammogram Referral	If client is referred for diagnostic mammogram, write the date of the referral in MM/DD/YYYY format.
Results of Mammogram	Mark the result of the mammogram. Work-up is required if a bold option is chosen.
Breast Work-up Planned	Mark if breast work-up planned. If "yes", mark the type of work-up.
	Breast Imaging/MRI
Referred for MRI	Mark if the client was referred for a screening MRI.
Paid by Take Charge! Program?	Mark if procedure was paid for by Take Charge! Program.
Facility Name	Enter the location where the MRI was provided.
Date Performed	Write the date of MRI in MM/DD/YYYY format.
Date Results Received	Write the date the provider received results in MM/DD/YYYY format.
Date Client Notified	Write the date client was notified of the results in MM/DD/YYYY format.
Results of MRI	Mark the result of the MRI. Work-up is required if a bold option is chosen.
Breast Work-up Planned	Mark if breast work-up planned. If "yes", mark the type of work-up.

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Part 6	Cervical Cancer Screening Information
Previous Pap test	Mark if client has received a Pap test in the past.
Facility	Enter the Facility where the previous Pap test was provided.
Date	Enter the date of the previous Pap test in MM/DD/YYYY format.
Hysterectomy?	Indicate whether or not client has had hysterectomy. The Take Charge! Program will cover the cost of one Pap Test after a hysterectomy.
Date	Enter the date of hysterectomy in MM/DD/YYYY format.
Previous Cervical cancer?	Mark if client has been diagnosed with cervical cancer in the past.
Date	Enter the date of previous cervical cancer diagnosis in MM/DD/YYYY format.
Past Abnormal Pap	Mark if client has had an abnormal Pap test in the past.
Year	Enter the 4-digit year of the last abnormal Pap test.
Type	Enter the result of the last abnormal Pap test.
Treatment Method	Enter the treatment method for the last abnormal Pap test.
Part 7A	Indication for Pap Test
Indication for Pap test	Mark the reason for receiving Pap test. Choose one only.
Part 7B	Risk for Cervical Cancer
Risk for Breast Cancer	Indicate if the client has risk of cervical cancer.
Part 7C	Pelvic Information
Type of Exam	Mark the type of exam.
Date of Exam	Enter the date of exam in the following format MM/DD/YYYY.
Paid by Take Charge! Program?	Mark if procedure was paid for by Take Charge! Program.
Results	Mark the result of the exam.
Clinical Comments	This section is an aid for the clinician. Please note that these comments are not entered in database.
Part 7D	Pap Test
Facility name	Enter the location where the Pap test was provided.
Date Pap test performed	Write the date of Pap test in the following format MM/DD/YYYY.
Specimen type for Pap test	Mark the specimen type.
Paid by Take Charge! Program?	Mark if procedure was paid for by Take Charge! Program. Mark "Yes" if a Take Charge contracted lab was used to process cervical and/or vaginal specimen.
Date results received	Write the date provider received results in MM/DD/YYYY format.
Date client notified	Write the date client was notified of the results in MM/DD/YYYY format.
Specimen adequacy	Mark the adequacy. Work-up is required if a bold option is chosen.
Results of Pap test	Mark the result of the Pap test. Work-up is required if a bold option is chosen.
Part 7E	INDICATION FOR HPV TEST
Indication for the HPV Test	Mark the reason for receiving HPV testing.
Part 7F	HPV TEST INFORMATION
HPV Performed?	Mark if HPV test was performed.
Date HPV Test Performed	Write the date of HPV test in MM/DD/YYYY format.
Paid by Take Charge! Program?	Mark if procedure was paid for by Take Charge! Program.
HPV Test Result	Mark the result of the HPV test. Work-up is required if a bold option is chosen.
Cervical Work-up Planned	Mark if cervical work-up planned. If "yes", mark the type of work-up.

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Part 8	Tobacco Use Information
Note to examiner: Ask the following set of questions from the client and mark their responses.	
Have you smoked at least 100 cigarettes in your entire life (5 packs=100 cigarettes)?	Mark if the client smoked at least 100 cigarettes in her lifetime.
Do you now smoke cigarettes?	Mark the frequency of use, if the client currently smokes cigarettes.
Do you currently use any other type of tobacco such as cigars, pipes, or smokeless tobacco?	Mark the frequency of use, if the client currently uses any other type of tobacco.
Do you currently use e-cigarettes or any other type of vapor products?	Mark the frequency of use, if the client currently uses e-cigarettes or any other type of vapor products.
Do you live with anyone who uses tobacco?	Mark if client lives with anyone who uses tobacco.
Was a fax referral for Quitline (Tobacco cessation) offered	Mark if Quitline referral was provided to the client. If "no", write the reason for not providing referral.
Was the fax referral accepted by the patient?	Mark if referral was accepted by the client. If "no", write the reason for not accepting.
Examiner's signature/Date	Clinician completing the screening must sign and date the form 274A when the form is completed. If the form is completed by another person other than the clinician that provided the care they must also sign and date the form, underneath the examiner's signature