Form 92 - Pap Smear

Comments:

- Affix label here-

Clinical Center/ID: __ __ __ __ - __ __ __ - __

First Name _____ M.I. _____

Last Name _____

1. Contact date: __-__-__ (M/D/Y)

2. Completed by: ___ _____

3. Contact type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other

4. Visit type:
   - ☐ 1 Screening #__
   - ☐ 2 Semi-Annual #__
   - ☐ 3 Annual #__
   - ☐ 4 Non-Routine

5. Pap smear collected by:
   - ☐ 1 CC staff
   - ☐ 2 Other
   - MD Name _____
   - Clinic Name: _____
   - Address _____
   - City/State/Zip _____

6. Date collected: __-__-__ (M/D/Y)

7. Date Pap smear report reviewed: __-__-__ (M/D/Y)

8. Report reviewed by: ___ _____

9. Cells present:

	No	Yes
9.1. Endometrial cells?	☐ 0	☐ 1
9.2. Atypical endocervical cells?	☐ 0	☐ 1
9.3. Atypical squamous cells?	☐ 0	☐ 1
9.4. If cervix present, endocervical cells?	☐ 0	☐ 1

9.5. Has woman ever had a Pap?
☐ 0 No ☐ 1 Yes

9.6. Has woman had only normal Paps in past 3 years?
☐ 0 No ☐ 1 Yes

9.7. Has woman had a history of dysplasia?
☐ 0 No ☐ 1 Yes

10. Results: *(Mark one.)*
   - ☐ 1 Normal (no atypical cells)

   If dysplasia category available:
   - ☐ 2 Abnormal, mild dysplasia, atypia
   - ☐ 3 Abnormal, moderate dysplasia
   - ☐ 4 Abnormal, severe dysplasia

   If Bethesda criteria available:
   - ☐ 5 Abnormal, low grade SIL, atypia
   - ☐ 6 Abnormal, high grade SIL
   - ☐ 7 Cancer
   - ☐ 8 Insufficient specimen, no results
   - ☐ 9 Slides damaged, cannot be read

11. Was a referral made for follow-up care?
   ☐ 0 No ☐ 1 Yes

   11.1. Referred by: ___ _____

   11.2. Date of referral: __-__-__ (M/D/Y)

   11.3. Referred to:
   - MD/Clinic: _____
   - Address: _____
   - _____
   - Phone: _____

12. Pap follow-up (biopsy results only):
   - ☐ 1 Normal
   - ☐ 2 Mild dysplasia, atypical cells
   - ☐ 3 Moderate to severe dysplasia, CIS, cancer

K _____ V _____