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:
   - ☐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? (No cervix ____)	☐0	☐1

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

    Other:
    - ☐10 ASCUS
    - ☐11 AGUS/AGCUS
    - ☐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: ______________________
    City, State, Zip ______________________
    Phone: ______________________

12. Final Follow-up Results (Mark one):
    - ☐1 Normal
    - ☐2 Mild dysplasia, low grade SIL, atypical cells
    - ☐3 Moderate to severe dysplasia, high grade SIL, CIS, cancer

K __________ V __________