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 _____