Project WISH—Women Into Staying Healthy
D.C. Department of Health
899 N. Capitol Street, NE
Washington, DC 20002 (202) 442-5900

WISH ID #_____

PROJECT WISH CERVICAL DIAGNOSTIC FORM

Name_____ Date of Birth_____

Date of Visit_____ Hospital/ Clinic_____

ALL SECTIONS MUST BE COMPLETED

COLPOSCOPY WITHOUT BIOPSY: ❑ Yes ❑ No

Procedure Date _____/_____/_____ (mm/dd/yyyy)

Procedure site: _____

RESULTS:
❑ Negative ❑ Abnormal, not suspicious for cancer
❑ Clearly Defined lesion of CIN ❑ Unsatisfactory
❑ Abnormal, suspicious for cancer ❑ Refused

COLPOSCOPY WITH BIOPSY/ECC: ❑ Yes ❑ No

Procedure Date _____/_____/_____ (mm/dd/yyyy)

Procedure site: _____

RESULTS:
❑ Negative ❑ CIN III/CIS
❑ Adenocarcinoma ❑ Invasive Carcinoma
❑ CIN I ❑ Other non-cancerous abnormality
❑ CIN II ❑ Refused

ENDOCERVICAL CURRETAGE (ECC): ❑ Yes ❑ No

Procedure Date: _____/_____/_____ (mm/dd/yyyy)

Procedure site: _____

RESULTS:
❑ Negative ❑ CIN III/CIS
❑ Adenocarcinoma ❑ Invasive Carcinoma
❑ CIN I ❑ Other non-cancerous abnormality
❑ CIN II ❑ Refused

LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP): ❑ Yes ❑ No

Procedure Date: _____/_____/_____ (mm/dd/yyyy)

Procedure site: _____

RESULTS:
❑ Negative ❑ CIN III/CIS
❑ Adenocarcinoma ❑ Invasive Carcinoma
❑ CIN I ❑ Other non-cancerous abnormality
❑ CIN II ❑ Refused

COLD KNFE CONE BIOPSY/CONIZATION: ❑ Yes ❑ No

Procedure Date: _____/_____/_____ (mm/dd/yyyy)

Procedure site: _____

RESULTS:
❑ Negative ❑ CIN III/CIS
❑ Adenocarcinoma ❑ Invasive Carcinoma
❑ CIN I ❑ Other non-cancerous abnormality
❑ CIN II ❑ Refused

Other: _____ ❑ Yes ❑ No

Procedure Date: _____/_____/_____ (mm/dd/yyyy)

Procedure site: _____

RESULTS:
❑ Negative ❑ CIN III/CIS
❑ Adenocarcinoma ❑ Invasive Carcinoma
❑ CIN I ❑ Other non-cancerous abnormality
❑ CIN II ❑ Refused

CERVICAL OUTCOME

STATUS OF FINAL DIAGNOSIS:
❑ Work-up Complete ❑ Work-up Pending
❑ Lost to Follow-up ❑ Refused

FINAL DIAGNOSIS:
❑ Normal/Benign/Inflammation ❑ CIN I/Mild Dysplasia
❑ HPV/Condylomata/Atypia ❑ CIN II/Moderate Dysplasia
❑ Low Grade SIL ❑ CIN III/Severe Dysplasia/CIS/AIS
❑ High Grade SIL ❑ Invasive Carcinoma
❑ Other _____

DATE OF STATUS OF DIAGNOSIS: ____/____/_____(mm/dd/yyyy)
(Date of cancer diagnosis/no cancer, work-up refused or lost to f/u)

DATE PATIENT NOTIFIED OF RESULTS: ____/____/_____(mm/dd/yyyy)

STATUS OF TREATMENT:
❑ Treatment Started ❑ Lost to Follow-up
❑ Treatment Pending ❑ Refused
❑Treatment Not Needed

DATE OF STATUS OF TREATMENT: ____/____/_____(mm/dd/yyyy)
(Date when treatment started, treatment refused or lost to follow-up)

MEDICAID ENROLLMENT (IF DIAGNOSED WITH CANCER ONLY):
❑Yes ❑ No, Why Not_____

CERVICAL DIAGNOSTIC PROCEDURE PAID FOR BY BCCEDP FUNDS
❑Yes ❑ No

PATIENT TRANSFERRED TO: ❑ VA BCCEDP ❑ MD BCCEDP

Clinician Comments:

Clinician Name: **Signature:** **Date:**