

## Attachment 9

### Chart Abstraction Form

**i. Chart Abstraction Information**

<b>i.1</b> This chart abstraction form is ( <i>check one</i> ):	<input type="checkbox"/> <b>a.</b> a consolidated form (i.e., combined records from all sources)	<input type="checkbox"/> <b>b.</b> a facility-specific form (i.e., record from one provider/facility only)
<b>i.2</b> If <b>i.1 = b</b> , enter Provider Study ID:	<b>If i.1 = a</b> , enter <i>Provider Study ID as indicated below in Tables I, II, and III</i>	

**A. Patient Demographics**

<b>A.1</b> Study ID Number:		<b>A.2</b> Month and Year of Birth: ____ / ____		
<b>A.3</b> Hispanic or Latino origin:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>A.4</b> Race ( <i>check all that apply</i> ):	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> African American	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown

**B. Cervical Cancer Diagnosis**

<b>5-year Review Period</b> <i>(registry to provide these dates)</i>	<b>B.1</b> Date 5 years prior to diagnosis ( <i>start of 5-year review period</i> ): ____ / ____ / ____ MM/DD/YY	<b>B.2</b> Date of diagnosis ( <i>end of 5-year review period</i> ): ____ / ____ / ____ MM/DD/YY
<b>B.3</b> Patient had tubal ligation prior to diagnosis ( <b>B.2</b> )? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>B.4</b> Did patient undergo a cervical procedure (e.g., LEEP or cold knife cone biopsy) prior to review period ( <b>B.1</b> )? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>B.5</b> Has the patient had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If B.5 = YES, complete B.6 and B.7</i> )		
<b>B.6</b> Date of hysterectomy: ____ / ____ / ____ MM/DD/YY		
<b>B.7</b> Was cervical cancer found as a result of the hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**C. Cervical Cancer Screening**

**C.1** Has patient had a PAP or HPV test during the 5-year review period?

Yes  No

(If **YES**, please complete TABLE I for all Pap and HPV results during the review period)

**Table I. Pap and HPV Testing, review period only**

	C.2	C.3	C.4	C.5	Pap Testing (if C.3 = Pap or Both)					HPV Testing (if C.3 = HPV or Both)					C.16	C.17
PAP, HPV	Date of Test(s)	Test(s) Performed	Test(s) Performed by	Provider Study ID (If i.1 = a)	Type of Pap	Lab where run? (Name)	Image-based evaluation?	Satisfactory test result?	Endocervical/ TZ component present?	Pap result (check all that apply)	Type of HPV	HPV result	HPV genotyping performed? (check all that apply)	Results of genotyping? (record result for each test in C.14)	Was patient referred to colposcopy/ treatment?	Did patient return for colposcopy/ treatment?
<b>1</b>	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
<b>2</b>	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
<b>3</b>	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/45	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported

	C.2	C.3	C.4	C.5	C.6	C.7	C.8	C.9	C.10	C.11	C.12	C.13	C.14	C.15	C.16	C.17
	Pap Testing (if C.3 = Pap or Both)										HPV Testing (if C.3 = HPV or Both)					
PAP, HPV	Date of Test(s)	Test(s) Performed	Test(s) Performed by	Provider Study ID (If i.1 = a)	Type of Pap	Lab where run? (Name)	Image-based evaluation?	Satisfactory test result?	Endocervical/TZ component present?	Pap result (check all that apply)	Type of HPV	HPV result	HPV genotyping performed? (check all that apply)	Results of genotyping? (record result for each test in C.14)	Was patient referred to colposcopy/treatment?	Did patient return for colposcopy/treatment?
													<input type="checkbox"/> Other: _____ <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A			
4	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/ 45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
5	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/ 45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
6	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/ 45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
7	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not

	C.2	C.3	C.4	C.5	C.6	C.7	C.8	C.9	C.10	C.11	C.12	C.13	C.14	C.15	C.16	C.17
	Pap Testing (if C.3 = Pap or Both)										HPV Testing (if C.3 = HPV or Both)					
PAP, HPV	Date of Test(s)	Test(s) Performed	Test(s) Performed by	Provider Study ID (If i.1 = a)	Type of Pap	Lab where run? (Name)	Image-based evaluation?	Satisfactory test result?	Endocervical/TZ component present?	Pap result (check all that apply)	Type of HPV	HPV result	HPV genotyping performed? (check all that apply)	Results of genotyping? (record result for each test in C.14)	Was patient referred to colposcopy/treatment?	Did patient return for colposcopy/treatment?
			<input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Not reported		<input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Not reported	<input type="checkbox"/> Not reported	<input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Not reported	reported
8	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
9	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
10	____/____/____ MM/DD/YY	<input type="checkbox"/> Pap <input type="checkbox"/> HPV <input type="checkbox"/> Both	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> STM/ Glass slide <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath <input type="checkbox"/> Not reported		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported or Not available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Normal <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC <input type="checkbox"/> Squamous CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Qiagen <input type="checkbox"/> Cervista <input type="checkbox"/> Roche Cobas <input type="checkbox"/> Aptima <input type="checkbox"/> Laboratory Developed Test (LDT) <input type="checkbox"/> Not Specific	<input type="checkbox"/> Positive HR <input type="checkbox"/> Negative HR <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not reported	<input type="checkbox"/> HPV 16 <input type="checkbox"/> HPV 18 <input type="checkbox"/> HPV 45 <input type="checkbox"/> HPV 18/45 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Rep. <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported

**D. Cervical Cancer Diagnostic Testing**

**D.1** Has patient had a COLPOSCOPY (*with or without CERVICAL or ENDOCERVICAL BIOPSIES*) during the 5-year review period?

Yes  No

(If **YES**, please complete TABLE II for all COLPOSCOPY and BIOPSY results during the review period)

**Table II. Colposcopies and Biopsies, review period only**

	D.2	D.3	D.4	D.5	D.6	D.7	D.8	D.9.a	D.9.b	D.9.c	D.9.d	D.10	D.11	D.12	D.13
						Cervical Biopsies (if D.6 = Cervical or Both)						ECC (if D.6 = ECC or Both)			
COLPOSCOPY	Date of colposcopy	Colposcopy performed by	Provider Study ID (if i.1 = a)	Were cervical biopsies or Endocervical Curettage (ECC) performed?	Type of Biopsy/ Biopsies (choose one)	Number of cervical biopsy specimens	Number of cervical biopsy test results returned	Cervical biopsy test results: specimen 1, or all specimens if combined (check all that apply)	Cervical biopsy test results: specimen 2 (check all that apply)	Cervical biopsy test results: specimen 3 (check all that apply)	Cervical biopsy test results: specimen 4 (check all that apply)	Endocervical Curettage (ECC) test results (check all that apply)	Was patient referred to treatment/ diagnosis?	Did patient return for treatment/ diagnosis?	Comments (e.g., biopsy results for more than 4 specimens)
1	MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to next colposcopy)	<input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical Curettage (ECC) <input type="checkbox"/> Both	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	
2	MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to next colposcopy)	<input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical Curettage (ECC) <input type="checkbox"/> Both	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported		

	D.2	D.3	D.4	D.5	D.6	D.7	D.8	D.9.a	D.9.b	D.9.c	D.9.d	D.10	D.11	D.12	D.13
	Cervical Biopsies (if D.6 = Cervical or Both)											ECC (if D.6 = ECC or Both)			
COLPOSCOPY	Date of colposcopy	Colposcopy performed by	Provider Study ID (If i.1 = a)	Were cervical biopsies or Endocervical Curettage (ECC) performed?	Type of Biopsy/ Biopsies (choose one)	Number of cervical biopsy specimens	Number of cervical biopsy test results returned	Cervical biopsy test results: specimen 1, or all specimens if combined (check all that apply)	Cervical biopsy test results: specimen 2 (check all that apply)	Cervical biopsy test results: specimen 3 (check all that apply)	Cervical biopsy test results: specimen 4 (check all that apply)	Endocervical Curettage (ECC) test results (check all that apply)	Was patient referred to treatment/ diagnosis?	Did patient return for treatment/ diagnosis?	Comments (e.g., biopsy results for more than 4 specimens)
3	MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if no, skip to next colposcopy)</i>	<input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical Curettage (ECC) <input type="checkbox"/> Both	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	
4	MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if no, skip to next colposcopy)</i>	<input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical Curettage (ECC) <input type="checkbox"/> Both	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> > 4	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Normal <input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> AIS <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> CA <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	

**E. Diagnosis**

**E.1** Was DIAGNOSIS OR TREATMENT PROCEDURE REQUIRED as a result of pap or biopsy test results during the 5-year review period?

Yes  No

(If **YES**, please complete TABLE III for all DIAGNOSTIC AND EXCISIONAL PROCEDURES RECEIVED during the review period.)

**Table III. Diagnostic procedures received, review period only**

PROCEDURE	E.1	E.2	E.3	E.4
	Date of diagnostic procedure/treatment	Diagnostic procedure/treatment performed by	Provider Study ID <i>(If i.1 = a)</i>	Type of diagnostic procedure/treatment <i>(check all that apply)</i>
<b>1</b>	____/____/____ MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> LEEP <input type="checkbox"/> Cold knife cone <input type="checkbox"/> CO2 Laser therapy <input type="checkbox"/> Cryo <input type="checkbox"/> Other: _____
<b>2</b>	____/____/____ MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> LEEP <input type="checkbox"/> Cold knife cone <input type="checkbox"/> CO2 Laser therapy <input type="checkbox"/> Cryo <input type="checkbox"/> Other: _____
<b>3</b>	____/____/____ MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> LEEP <input type="checkbox"/> Cold knife cone <input type="checkbox"/> CO2 Laser therapy <input type="checkbox"/> Cryo <input type="checkbox"/> Other: _____
<b>4</b>	____/____/____ MM/DD/YY	<input type="checkbox"/> Family practice <input type="checkbox"/> Primary care physician <input type="checkbox"/> Gynecologist <input type="checkbox"/> Gyn/onc <input type="checkbox"/> Advanced Practice Clinician (APN, PA, NP) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> LEEP <input type="checkbox"/> Cold knife cone <input type="checkbox"/> CO2 Laser therapy <input type="checkbox"/> Cryo <input type="checkbox"/> Other: _____



**F. Other Patient History**

<p><b>F.1</b> Has patient experienced symptoms of cervical disease <u>during the 5-year review period?</u></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(IF F.1 = YES, complete F.2)</i></p>	<p><b>F.2</b> Check all that apply.</p>	<p><input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Discharge <input type="checkbox"/> Pain <input type="checkbox"/> Urinary symptoms <input type="checkbox"/> Other</p>
--	--	---	---