Attachment 9

Chart Abstraction Form

i. Chart Abstraction Information

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

A. Patient Demographics

A.1 Study ID Number:		**A.2** Month and Year of Birth: ____ /____		
A.3 Hispanic or Latino origin:		☐ Yes	☐ No	☐ Unknown
A.4 Race *(check all that apply)*:	☐ White/Caucasian	☐ Asian	☐ Native Hawaiian/Pacific Islander	
	☐ African American	☐ American Indian/Alaskan Native	☐ Other	☐ Unknown

B. Cervical Cancer Diagnosis

5-year Review Period *(registry to provide these dates)*	**B.1** Date 5 years prior to diagnosis (*start* of *5-year review period*): ____ /____ /____ MM/DD/YY	**B.2** Date of diagnosis (*end* of *5-year review period*): ____ /____ /____ MM/DD/YY
B.3 Patient had tubal ligation prior to diagnosis (**B.2**)? ☐ Yes ☐ No		
B.4 Did patient undergo a cervical procedure (e.g., LEEP or cold knife cone biopsy) prior to review period (**B.1**)? ☐ Yes ☐ No		
B.5 Has the patient had a hysterectomy? ☐ Yes ☐ No *(If B.5 = **YES**, complete B.6 and B.7)*		
B.6 Date of hysterectomy: ____ /____ /____ MM/DD/YY		
B.7 Was cervical cancer found as a result of the hysterectomy? ☐ Yes ☐ 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**	**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?**
1	___/___/___ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ___________		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ___________	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ______	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported
2	___/___/___ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ___________		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ___________	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ______	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported
3	___/___/___ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ___________		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify)	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported

PAP, HPV	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)*					
	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?**
										______			☐ Other: ______	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A		
4	__/__/__ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ______		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ______	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ______	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported
5	__/__/__ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ______		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ______	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ______	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported
6	__/__/__ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ______		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ______	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ______	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported
7	__/__/__	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima	☐ Positive HR ☐ Negative HR ☐ Indeterminate	☐ HPV 16 ☐ HPV 18	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No	☐ Yes ☐ No ☐ Not

PAP, HPV	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)*					
	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?**
			☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ________________		☐ Not reported		☐ Not reported or Not available	☐ Not reported	☐ Not reported	☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ____________	☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Not reported	☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ________	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Not reported	reported
8	___/___/___ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ________________		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ____________	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ________	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported
9	___/___/___ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ________________		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ____________	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ________	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported
10	___/___/___ MM/DD/YY	☐ Pap ☐ HPV ☐ Both	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ________________		☐ STM/ Glass slide ☐ ThinPrep ☐ SurePath ☐ Not reported		☐ Yes ☐ No ☐ Not reported or Not available	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	☐ Normal ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ AGC ☐ Squamous CA ☐ Other (specify) ____________	☐ Qiagen ☐ Cervista ☐ Roche Cobas ☐ Aptima ☐ Laboratory Developed Test (LDT) ☐ Not Specific	☐ Positive HR ☐ Negative HR ☐ Indeterminate ☐ Not reported	☐ HPV 16 ☐ HPV 18 ☐ HPV 45 ☐ HPV 18/ 45 ☐ Other: ________	☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A ☐ Pos. ☐ Neg. ☐ Not Rep. ☐ N/A	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ 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 colpo-scopy**	**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	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ________		☐ Yes ☐ No *(if no, skip to next colposcopy)*	☐ Cervical ☐ Endocervical Curettage (ECC) ☐ Both	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	
2	__/__/__ MM/DD/YY	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ________		☐ Yes ☐ No *(if no, skip to next colposcopy)*	☐ Cervical ☐ Endocervical Curettage (ECC) ☐ Both	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) ________	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	

COLPOSOPY	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)*			
	Date of colpo-scopy	**Colposcopy performed by**	**Provider Study ID** *(If i.1 = a)*	**Were cervical biopsies or Endocervical Curettage (ECC) performed?**	**Type of Biospy/ 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	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ____________		☐ Yes ☐ No *(if no, skip to next colposcopy)*	☐ Cervical ☐ Endocervical Curettage (ECC) ☐ Both	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ Not reported	
4	__/__/__ MM/DD/YY	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ____________		☐ Yes ☐ No *(if no, skip to next colposcopy)*	☐ Cervical ☐ Endocervical Curettage (ECC) ☐ Both	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Normal ☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ CIN2/3 ☐ AIS ☐ LSIL ☐ HSIL ☐ CA ☐ Other (specify) __________	☐ Yes ☐ No ☐ Not reported	☐ Yes ☐ No ☐ 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** Date of diagnostic procedure/treatment	**E.2** Diagnostic procedure/treatment performed by	**E.3** Provider Study ID *(If i.1 = a)*	**E.4** Type of diagnostic procedure/treatment *(check all that apply)*
1	____/____/____ MM/DD/YY	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ____________________		☐ LEEP ☐ Cold knife cone ☐ CO2 Laser therapy ☐ Cryo ☐ Other: __________________
2	____/____/____ MM/DD/YY	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ____________________		☐ LEEP ☐ Cold knife cone ☐ CO2 Laser therapy ☐ Cryo ☐ Other: __________________
3	____/____/____ MM/DD/YY	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ____________________		☐ LEEP ☐ Cold knife cone ☐ CO2 Laser therapy ☐ Cryo ☐ Other: __________________
4	____/____/____ MM/DD/YY	☐ Family practice ☐ Primary care physician ☐ Gynecologist ☐ Gyn/onc ☐ Advanced Practice Clinician (APN, PA, NP) ☐ Other (specify) ____________________		☐ LEEP ☐ Cold knife cone ☐ CO2 Laser therapy ☐ Cryo ☐ Other: __________________

F. Other Patient History

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