Ministry of Public Health and Sanitation
Ministry of Medical Services

Cervical Cancer Screening Form

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Client Number: Date (dd/mm/yyyy)

Client Name: _____ Age: _____ Phone no: _____

Service area: ☐ MCH/FP ☐ CCC ☐ GOPC ☐ Outreach ☐ Other

Facility Name and Code: _____ County: _____ District: _____

Visit Type (*pick only one visit type and mark with an X in the box*):

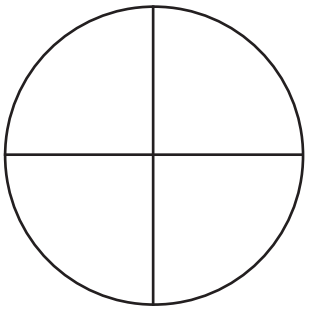
☐ Screening → ☐ Initial ☐ Routine Rescreening ☐ 1 Year Follow-Up Visit Post treatment

☐ Postponed Cryotherapy Visit

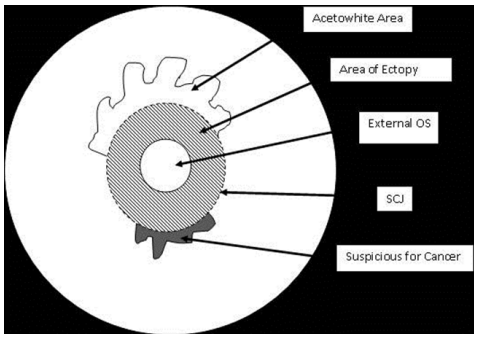
☐ Post-Treatment Complication - Related to: ☐ Cryotherapy ☐ LEEP ☐ Other (specify):

☐ Other Cervical Cancer related treatment (Advanced Care Sites only), Specify

Cervical Map: (for VIA/ VILI/ Colposcopy)



Illustration/Key



Screening Method and Result:

☐ VIA → ☐ VIA Negative ☐ VIA Positive ☐ Suspicious for Cancer ☐ Other (specify):

☐ VILI → ☐ VILI Negative ☐ VILI Positive ☐ Suspicious for Cancer ☐ Other (specify):

☐ Pap smear → ☐ Low Grade Lesion ☐ High Grade Lesion ☐ Invasive Cancer ☐ Other (specify):

☐ HPV Test → ☐ Negative Positive

Treatment:

☐ Screening today, Cryotherapy performed today (Single Visit Approach -SVA)

☐ Screening today, Cryotherapy postponed; Reason: _____

☐ Postponed Cryotherapy done today

☐ Other cervical cancer specific treatment performed today (e.g. LEEP): _____

☐ Treatment for other ailments (specify): _____

Referral OUT:- Referred to: _____ **Reasons:** (tick below)

☐ Site does not have cryotherapy machine

☐ Large lesion Results of Large Lesion Referral: ☐ LEEP performed ☐ other: _____

☐ Suspect cancer Results of Suspect Cancer Referral: ☐ cancer confirmed ☐ cancer not confirmed

☐ Other Gynecological problem (specify):

HIV Status: ☐ Positive ☐ Negative ☐ Unknown

Follow up Date / Next Appointment: _____

Provider's Name: _____ Cadre: _____ Signature _____

Ministry of Public Health and Sanitation
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