Take Charge Screening and Diagnostic Services ODH Form No. 1342

Send Completed Form to Take Charge via secure email/fax to CancerPCP@health.ok.gov or 405-900-7609

Part 1: DEMOGRAPHICS

Clinic name: | Clinic site number: | Social security number: | Age:

Last name: | First name: | MI: | Maiden:

DOB: | Daytime phone number: | Evening phone number:

Address: | City: | State: | Zip:

Is patient pregnant: ☐ No ☐ Yes Due date of pregnancy: | Meets Income Guidelines: ☐ Yes ☐ No

Interpreter needed?: ☐ Yes ☐ No | Translation type: ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Unknown | Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Part 2: CURRENT BREAST AND/OR CERVICAL FINDINGS

Procedure	Findings	Location	Date	Duration of Symptoms

Part 3: PREVIOUS BREAST AND/OR CERVICAL DIAGNOSTIC PROCEDURES

Procedure	Diagnosis	Date	Facility Name

Part 4: SERVICE REQUESTED

Breast Services	Cervical Services
☐ Screening Mammogram (initial or routine)	☐ LEEP
☐ Diagnostic Mammogram (check reason below) ☐ Left breast ☐ Right breast ☐ Abnormal Finding ☐ Implants ☐ Follow-up Mammogram	☐ Colposcopy ☐ Colposcopy with Biopsy ☐ Cervical Specialist Consultation
☐ Breast Ultrasound ☐ Left breast ☐ Right breast	☐ Short Term Follow-Up Office Visit or Post Treatment Office Visit
☐ Ultrasound or Stereotactic Guided Breast Biopsy	Additional breast and/or cervical clinical comments:
☐ Screening MRI ☐ Left breast ☐ Right breast	
☐ Fine Needle Aspiration (with/without imaging guidance)	
☐ Breast Specialist Consult (Films and records must be sent to appointment.)	

Part 5: APPOINTMENT INFORMATION

Date: Time:

Name of facility:

Phone number of facility:

Address of facility:

Additional appointment instructions:

Part 6: REFFERAL INFORMATION

Name of referring provider:

Referring provider phone number:

Referring provider fax number:

Referring provider address:

Issue date: _____ Expiration date: _____
(60 days after issued date)

Send report by: ☐ Fax ☐ Mail

OKLAHOMA State Department of Health

Submit

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Please type answers (preferred) or write neatly on the form using black ink. If a client has both a breast and cervical symptom, a separate form should be issued for each symptom.

For County Health Departments who have fully implemented Take Charge, utilize Med-IT to enter client information. If full implementation has not occurred, proceed to use ODH Form 1342 and these instructions.

Part 1	Demographics
Clinic name	Write the clinic name in this box.
Clinic site number	Write the four-digit number that is assigned to your clinic, if applicable.
Social security number	Write the client's social security number. If the client does not have a social security number, write the word "NONE".
Age	Write the client's age on the date of the visit.
Last name	Ask the client to spell their last name and then write the information in this box.
First name	Ask the client to spell their first name and then write the information in this box.
MI	Ask the client their middle initial and then write the information in this box.
Maiden	Ask the client to spell their maiden name (if applicable) and then write the information in this box.
DOB	Write the client's date of birth in the following format MM/DD/YYYY.
Daytime phone number	Write the client's daytime phone number, including the area code.
Evening phone number	Write the client's evening phone number, including the area code.
Address, city, state, zip	Write the client's mailing address, city, state, and zip code. If the client does not have a mailing address, please enter a finding address (friend's address, significant other's address, etc.,) contact information, and notate that it is a finding address.
Pregnancy information	Mark either "yes" or "no" if client is pregnant. If she is pregnant, enter due date.
Meets income guidelines	Mark "yes" or "no" if client meets current income guidelines.
Interpreter needed	Mark either "yes" or "no" if the client needs an interpreter.
Translation type	If the client needs an interpreter, please indicate the type. This will help the facility be prepared for the appointment.
Race	Mark "one" or "more" of the client's self-reported race.
Ethnicity	Mark the client's self-reported ethnicity.
Part 2	**Current Breast and/or Cervical Finding**
Procedure	Write the recently performed procedure(s)
Findings	Enter all information for breast or cervical finding identified by the provider. Breast findings should be entered as follows: normal, benign, discrete palpable mass, bloody or serous nipple discharge, nipple or areolar scaliness, or skin dimpling or retraction. Cervical findings should be entered as follows: negative for lesion/malignancy, LSIL, ASCUS, squamous cell carcinoma, AGC, ASC-H, adenocarcinoma, or HSIL.
Location	Enter the location of the identified breast or cervical finding.
Date	Enter the date of the identified breast or cervical finding.
Duration	
Part 3	**Previous Breast and/or Cervical Diagnostic Procedure**
Procedure	Write the previously performed procedure(s).
Diagnosis	Enter the diagnosis from the previous procedure listed above.
Date	Write the date of the procedure(s). If unknown, write the approximate date or unknown.
Facility name and contract information	Write the name of the facility and contact information if the client had a procedure from another facility for breast or cervical diagnostic services.

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Part 4	Service Requested
Breast services	Mark the service that the client needs. If a service is not listed on the form, then the service will not be covered by Take Charge. **Clients from (non-Take Charge) County Health Department are only eligible for diagnostic services.**
Cervical services	Mark the service that the client needs. If a service is not listed on the form, then the service will not be covered by Take Charge. **Clients from (non-Take Charge) County Health Department are only eligible for diagnostic services.**
Additional breast and/or cervical comments	Write any comments that would be clinically pertinent for the facility that is performing the service. For example, if a client has a personal history of breast cancer or if a family member has had breast cancer.
Part 5	**Appointment Information**
Date/time	Write the date and time of the client's appointment, if known.
Name of facility	Enter the name of the facility that will provide the service for the client. Ensure that the provider is a Take Charge contractor or the cost of the services will not be covered.
Phone number of facility	Enter the phone number (including the area code) of the facility that is providing the service.
Address of facility	Enter the physical address of the facility that is providing the service. Give a map or written directions to assist the client with finding the facility.
Additional appointment instructions	Enter information for the client that would be helpful, like instructions prior to having a mammogram or a colposcopy.
Part 6	**Referral Information**
Name of referring provider	Enter the name of the referring provider. Failure to provide information will delay receipt of results.
Referring provider phone number	Enter the phone number of the referring provider. Failure to provide this information may delay receipt of results.
Referring provider fax number	Enter the fax number of the referring provider. Failure to provide information will delay receipt of results.
Referring provider address	Enter the mailing address of the referring provider. Failure to provide this information will delay receipt of results.
Issue date/expiration date	Write in date the form was issued and the expiration date (60 days from issue of form).
Send report by	Mark fax to receive results by fax or mark mail to receive results by mail.

General Instructions for Referring Provider:
Once the ODH Form 1342 is completed, hit the green SUBMIT button located at the bottom of the form to create an email with the completed form attached. Attach provider/medical orders and any other relevant documentation to the email.

Once ODH Form 1342 and required documentation is received, a Take Charge Patient Navigator will determine eligibility for the client. Updates will be provided to referring provider. Once approved, clients will need to be referred to current contracted facilities for diagnostic services. An updated list of facilities can be found at the bottom of the "Current Providers" page of the Take Charge website. Any procedure other than a normal screening mammogram for women 40 and older requires approval from the Take Charge Staff.

Contact Take Charge staff via email CancerPCP@health.ok.gov or the toll free line 1-888-669-5934 with any questions.

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Take Charge Eligibility Guidelines

To be eligible for the Take Charge Program a client must meet age, income, residency, and insurance status.

1. Age and Service Eligible to Receive through Take Charge Program

Age	**Sterilization**	**Service(s) covered**
21-39 years old	Not surgically sterilized (tubal/hysterectomy)	Only for diagnostic services (with sign/symptom of cancer) with referral. *(Women who are eligible for Family Planning Waiver should be screened through Family Planning Program)*
21-39 years old	Surgically sterilized (tubal/hysterectomy)	Clinical Breast Exam (CBE), Pelvic Exam, and Pap Test, diagnostic services (as needed) with sign/symptom of cancer
40-49 years old	Not surgically sterilized (tubal/hysterectomy)	Only for screening mammogram, with referral (CBE must be done prior to applying) and/or diagnostic services (with sign/symptom of cancer) with referral.
40-49 years old	Surgically sterilized (tubal/hysterectomy)	Clinical Breast Exam (CBE), Pelvic Exam, and Pap Test, screening mammogram, diagnostic services (as needed) with sign/symptom of cancer
50 years and older	Surgically sterilized or not	Clinical Breast Exam (CBE), Pelvic Exam, and Pap Test, screening mammogram, diagnostic services (as needed) with sign/symptom of cancer
Any age	Surgically sterilized or not	Diagnostic services with sign/symptom of cancer, with referral
65 years and older	Surgically sterilized or not	Please use current clinical guidance from USPTS, NCCN, ACS and etc. to determine if screening is clinically necessary.

**Patients needing diagnostic screening beyond diagnostic mammogram and ultrasound should apply for Oklahoma Cares, if eligible.*

2. Income

   A. Ask the client, "What is the total income for your family?"

   B. Ask the client, "How many family members are supported by that income?"
   Please note: The total family income includes: wages, tips, savings, net income from farm, self-employment, unemployment compensation, alimony, royalties, rental income, pension, retirement, savings, or bonds. Family income is any income or funds that the client has access to for the purchase of food, clothing, shelter, entertainment, or health care. If the client's total, household income is **more** than amount listed for the size of the family unit **they do not qualify**. There is no need to ask for proof of income by reviewing checking stubs, tax records, etc.

   C. Compare the answers with the current Poverty Guideline table on the Take Charge program website under "Eligibility".

3. Self-declared Oklahoma resident

4. Uninsured or have an unmet deductible of $150.00 of more