FILE IN LAB SECTION

HCH DIAGNOSTIC TESTING FOLLOW-UP FORM

Date: _____

Client Date of Birth: _____ **SS#:** _____

Type of Diagnostic Test (circle one):

1. **PAP Smear**

   Date of Test _____

2. **Mammogram**

   Date of Test _____

3. **Radiologic Procedure**

   Date of Test _____

4. **Other Testing Procedure**

   Date of Test _____

PAP Smear Results (circle one):	Mammogram Results (circle one):	Other Lab/X-ray, etc.
1. Normal	1. Normal	
2. Abnormal	2. Abnormal	
PAP Smear Follow-up Note:	**Mammogram** Follow-up **Note:**	
1. Repeat PAP ASAP	1. Repeat ASAP	
2. Repeat PAP 6 months	2. Repeat 6 months	
3. Refer to GYN	3. Repeat 1 year	
4. Repeat in 1 Year	4. Refer to Surgery	

Tracking (circle method used):	**Other Follow-up/Plan of Care:**
1. Abnormal Lab Letter Sent	
2. E-mail sent to HCH providers	
3. Other: _____	

Provider Signature _____ **Date** _____

CLIENT LAST NAME:		FIRST:		HCH#:	