CALIFORNIA EMERGING INFECTIONS PROGRAM
Human Papillomavirus Vaccine Impact Monitoring Project
(HPV-IMPACT)

CASE REPORT FORM

The purpose of this form is to collect missing patient information on cases of cervical pre-cancers under public health surveillance (see http://ceip.us/projects/hpv-impact/).

All reported information will be maintained in the strictest confidence. Questions? Contact Erin Whitney at (510) 620-2379.

PLEASE COMPLETE BY __/__/____ and fax to our confidential fax line (916) 440-5109

PATIENT INFORMATION:

Patient Name – Last	First	Last 4 #'s of SSN	Medical Record #	Patient ID: Date of Birth	Age

Patient Street Address	City	State	Zip

PROVIDER INFORMATION:

Provider Name	Practice Name	Provider Phone #	Provider Fax #

Provider Street Address	City	State	Zip

CERVICAL PATHOLOGY:

Specimen Collection Date	Pathology Lab	Procedure	Final Diagnosis

PATIENT RACE & INSURANCE INFORMATION:

1. Race (check all that apply)
☐ Unknown
☐ White
☐ Asian
☐ Black or African American
☐ American Indian / Alaska Native
☐ Native Hawaiian / Other Pacific Islander
☐ Other _____

2. Ethnicity
☐ Unknown ☐ Hispanic / Latino ☐ Not Hispanic / Latino

3. Insurance (check all that apply)
☐ Private / HMO / PPO / managed care program
☐ MediCal
☐ FPACT
☐ Indian Health Service
☐ Medicare
☐ Other _____
☐ Military / VA
☐ Self-pay
☐ No coverage
☐ Unknown

HPV VACCINE HISTORY:

4. Is the patient's HPV vaccination status documented in their chart? ☐ Yes ☐ No **(If No, skip to #5)**
→ **If documented, has the patient received the HPV vaccine?** ☐ Yes ☐ No
→ **If received, number of doses?** _____. **AND,** please provide information for each dose below.

Date of 1st dose	**Date of 2nd dose**	**Date of 3rd dose**
____/____/_____ ☐ Unknown	____/____/_____ ☐ Unknown	____/____/_____ ☐ Unknown
Did your office administer the 1st dose? ☐ Yes ☐ No ☐ Unknown	**Did your office administer the 2nd dose?** ☐ Yes ☐ No ☐ Unknown	**Did your office administer the 3rd dose?** ☐ Yes ☐ No ☐ Unknown
Type of vaccine – 1st dose ☐ Nonavalent (Gardasil 9®) ☐ Bivalent (Cervarix®) ☐ Quadrivalent (Gardasil®) ☐ Unknown	**Type of vaccine – 2nd dose** ☐ Nonavalent (Gardasil 9®) ☐ Bivalent (Cervarix®) ☐ Quadrivalent (Gardasil®) ☐ Unknown	**Type of vaccine – 3rd dose** ☐ Nonavalent (Gardasil 9®) ☐ Bivalent (Cervarix®) ☐ Quadrivalent (Gardasil®) ☐ Unknown
Age at 1st dose	**Age at 2nd dose**	**Age at 3rd dose**

PAP AND HPV TESTING HISTORY:

The following section refers to the Pap and HPV tests immediately **BEFORE** ___/___/_____.
Do not include any Pap or HPV tests done on or after this date.

5. Pap test done?
☐ Yes ☐ No
☐Unknown
Date of last Pap test
___/___/_____
(collection date)

Result of Pap test
☐ Normal
☐ ASCUS/ASC
☐ ASC-H
☐ AGUS/AGC
☐ LSIL
☐ HSIL
☐ AIS
☐ Other _____
☐ Unknown

HPV test done?
☐ Yes ☐ No
☐Unknown
Date of last HPV test
___/___/_____
(collection date)

Result of HPV test
☐ High risk positive ☐ High risk negative ☐ Unknown
HPV Types (if type-specific test used; check all that apply)
☐ HPV16 ☐ HPV18 ☐ Unknown
HPV test type ☐ Cervista® ☐ Aptima® ☐ HC2®
☐ cobas® ☐ Other_____ ☐ Unknown

UNDERLYING ILLNESSES:

6. Is the patient immunocompromised for any reason (e.g. HIV/AIDS, chronic steroid use)? ☐ Yes ☐ No ☐ Unknown