Texas Department of State Health Services
Breast and Cervical Cancer Control Program
Comprehensive Case Management Form

Contractor, Clinic Name:	Case Manager:	Patient ID Number:	Chart Number:

CLIENT INFORMATION

Name:	Date of Birth:	Social Security No.:	Daytime Phone:

Screening/Diagnosis results:	Other Contact Information:			
	Name:	Address:	Phone:	Relationship:

ASSESSMENT DATE

Social Resources Assessment	Medical Care/Service Status	Education and Counseling Assessment
☐ Social Support (e.g., Family, Church, Friends) ☐ Other	☐ Medical Home ☐ Transportation ☐ Language Barrier ☐ Unable to leave work ☐ Child Care ☐ Making Appointment ☐ Financial Resources ☐ Alternative Healing ☐ Other	☐ Concern about procedure (e.g., discomfort, pain) ☐ Embarrassment ☐ Fear of cancer ☐ Overwhelmed by information ☐ Feelings of anger, sadness ☐ Relationship with spouse/friends ☐ Intimacy/sexual concerns ☐ Body image ☐ Cost of procedures ☐ Loss of employment ☐ Other

SERVICE PLAN DATE

Identified Need	Service/Referral	Provider	Date of Initial Svc./Ref.	F/U Date	Outcome of Service/Referral

STATEMENT OF UNDERSTANDING

I understand that my participation in the BCCCP means that I agree to additional evaluation and/or treatment if any of my test results are abnormal.

(Signed):_____ Date:_____

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