TBCSP APPROVAL FOR DIAGNOSTIC PROCEDURES FOR CERVICAL ABNORMALITIES

PLEASE SEND ELECTRONICALLY TO YOUR LOCAL COORDINATOR

Region:		**Clinic:**	
Coordinator:		**Navigator:**	

Date:		**Client Name:**			
Screening Site:		**Client DOB:**		**Age:**	
Contact Person:		**Client SSN:**			
Phone:		**Client Phone:**			
Fax:		**Client Address:**			
Email:					

Procedure Requested:	☐ LEEP or LLETZ	☐CKC	☐ EMB

Previous Cervical Test Results		**Current Cervical Test Results**	
Date:		Date:	
Cytology Result:		Cytology Result:	
HR HPV Result:	☐ +16 ☐ +18 ☐ 12 Other HR Types ☐ Negative	HR HPV Result:	☐ +16 ☐ +18 ☐ 12 Other HR Types ☐ Negative
Previous Colposcopy		**Current Colposcopy**	
Date:		Date:	
Biopsy Result:		Biopsy Result:	

Justification for Request: ☐ **SUPPORTING DOCUMENTATION ATTACHED (required)**

Staff Requesting Procedure(s):	
Name:	**Date:**
Signature:	
TBCSP Staff Authorizing Procedure(s):	
Name:	**Date:**
Signature:	

Please note: Regional coordinators are allowed to approve cervical diagnostic procedures according to the TBCSP Policies and Procedures Manual and the current TBCSP Fee Reimbursement Schedule and is subject to change. Coordinators are required to submit all approvals or denials to Central Office with documentation. Any questions or concerns can be forwarded to Yoshie and Ellie for review.