NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

NM Breast and Cervical Cancer Early Detection (BCC) Program
Clinic-Based Patient Navigation (PN) Form
FY24: July 2023 – June 2024

CLINIC AND LOCATION/CITY:

BCC ENROLEE NAME: _____ **DOB:** **AGE:**

ADDRESS: _____ **CITY:** **ZIP:**

TELEPHONE NUMBER(S): **PREFERRED LANGUAGE:** **ID#:**

Navigated by (list all): _____

Patient Navigation Initiation Date: _____ ☐ **Check box if form is an UPDATE to a previously submitted PN form.**

Reason for Initiating Navigation: reimbursement for BCC enrolled people only

BREAST: ☐ **Screening** ☐ **Follow-up of Abnormal Results** ☐ **Treatment Initiation**

CERVICAL: ☐ **Screening** ☐ **Follow-up of Abnormal Results** ☐ **Treatment Initiation**

CDC/NBCCEDP Timeliness Guidelines:
- 60-days from abnormal breast/cervical screening to diagnosis
- 60-days from breast/cervical cancer diagnosis to treatment

Date of Abnormal Screening Result: _____ **Date of Final Diagnosis:** _____ **Date Treatment Started:** _____

BARRIER MARK ALL THAT APPLY	For each actual contact, MUST record: date of contact, how contacted, and a short description of the conversation between client and navigator including all barriers identified and the plan for resolution. Actual contact means the client and navigator spoke. At least 3 actual contacts are recommended; must be no fewer than 2 for reimbursement.
☐ Language or Cultural Concerns	Actual Contact #1 - Date:_____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)
☐ Cost, Financial, or Insurance Coverage	
☐ Transportation Issues	
☐ Child or Elder Care, or Other Family Obligations	Actual Contact #2 - Date:_____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)
☐ Fear of Medical Test(s) or Cancer	
☐ School, Work Schedule or Employment	
☐ Understanding Medical Needs	Actual Contact #3 - Date:_____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)
☐ Discomfort, Pain, Disabilities, or Other Health Issues	
☐ OTHER: _____	

Outcome of Patient Navigation: Mark box and add notes if needed.

☐ **Complete**	
☐ **Incomplete**	
☐ **In Process**	

Total Actual Contacts: _____

(3 OR MORE ACTUAL CONTACTS RECOMMENDED BUT MUST HAVE AT LEAST 2)

CLOSEOUT DATE: _____

Submit completed form to assigned BCC Program Nurse Coordinator for review and approval for reimbursement.

Revised July 2023

CLIENT NAME: _____ **DOB:** _____

Actual Contact #4 - Date: _____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)

Actual Contact #5- Date: _____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)

Actual Contact #6 - Date: _____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)

Actual Contact #7 - Date: _____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)

Actual Contact #8 - Date: _____ How Spoke with Client: ☐ In-Person ☐ Phone ☐ Other (e.g., Telehealth Visit)