

Cervical Diagnostic Enrollment / Follow Up and Treatment Plan for Women 21 - 74

Reasonable accommodations made for persons with disabilities. TDD (800)833-7352. Nebraska DHHS provides language assistance at no cost to limited English proficient persons who seek our services.

Version July 2013
(blue)

Every Woman Matters



301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth
www.dhhs.ne.gov/menshealth
www.dhhs.ne.gov/crc

Please write clearly. Shaded boxes must be filled in on pages 1 and 2 and page 2 must be signed. Fill in as much of the rest of this page as you can.

**If client previously enrolled for screening services see note on left edge of the form*.
NOTE: Male clients are NOT eligible for screening or diagnostic procedures.**

*Provider: If client previously enrolled for screening services complete ONLY the name, date of birth, phone number, and address on the first page.

First Name		Middle Initial	Last Name		Maiden Name	Birthdate / /
Gender M / F		Social Security #		Address		
City				County	State	Zip
<input type="checkbox"/> Please check box if you would like to receive client newsletter and/or program updates on your email.						
Email Address						
Home Phone () () ()			Work Phone () () ()		Cell Phone () () ()	
<i>In case we can't reach you:</i> Contact person: _____ Relationship: _____ Phone: () () () _____ Address: _____ City: _____ State: _____ Zip: _____				How did you hear about the program? <input type="checkbox"/> doctor/clinic <input type="checkbox"/> family/friend <input type="checkbox"/> agency <input type="checkbox"/> newspaper/radio/TV <input type="checkbox"/> self-referral <input type="checkbox"/> outreach worker <input type="checkbox"/> other _____		
				Highest grade in school you completed: <i>circle one</i> 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+		
What race or ethnicity are you? <input type="checkbox"/> American Indian/Alaska Native Tribe _____ <input type="checkbox"/> Black/African American <input type="checkbox"/> Mexican American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown				Are you of Hispanic/Latina origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Country of origin _____		
				What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		
<i>I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills.</i>						
What is your household income before taxes? <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Income: \$ _____ <input type="checkbox"/> Yearly _____ <i>Please Note: Self employed are to use net income after taxes.</i>				Do you have: <input type="checkbox"/> Medicare Part A and B <input type="checkbox"/> Medicare Part A only <input type="checkbox"/> Medicaid (full coverage for self) <input type="checkbox"/> None/No Coverage <input type="checkbox"/> Private Insurance with or without Medicaid Supplement (please list) _____		
How many people live on this income?				Is your insurance an HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No (An HMO is a health maintenance organization)		

BREAST & CERVICAL:		FAMILY & PERSONAL HISTORY	
Has your <i>mother, sister or daughter</i> ever had breast cancer?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	
Have you ever had breast cancer?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	
Have you ever had a hysterectomy (<i>removal of the uterus</i>)?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	
Was it to take care of cancer?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know When: ____/____/____	
Have you ever had any of the following tests?:			
Pap test _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		Date ____/____/____	
What did your doctor say about your exam? _____		Was your exam: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Mammogram (<i>breast x-ray</i>) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		Date ____/____/____	
What did your doctor say about your exam? _____		Was your exam: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

MUST READ AND SIGN BACK

Informed Consent and Release of Medical Information

■ You must read page 2 to be a part of the Every Woman Matters Program. You are NOT enrolled until page 2 is signed and dated.

July 2013

- ❖ I want to be a part of the **Every Woman Matters (EWM) Program**. I know:
 - ❖ I can only receive cervical diagnostic tests
 - ❖ I cannot be over income guidelines
 - ❖ I cannot have Medicaid, Medicare Part B, or an HMO
 - ❖ I must be a female (per Federal Guidelines)
 - ❖ I can notify EWM if I do not wish to be a part of this program anymore
- ❖ I know that if I am under 40 years of age, I will not be a part of EWM after I have had my cervical cancer diagnostic tests.
- ❖ I know that if I am 40-74 years of age, I may receive breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon program guidelines. I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.
- ❖ I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.
- ❖ I have talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM.
- ❖ I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- ❖ Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
- ❖ My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and cervical cancer screening, heart disease and diabetes screening, follow up exams, colorectal screening, diagnostic tests and/or treatment to EWM.
- ❖ To assist me in making the best health care decisions, EWM may share clinical and other health care information including lab results and health history with my health care providers.
- ❖ My name, address, email, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- ❖ Other information may be used for studies approved by EWM and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

In order to be eligible for EWM you must be a U.S. Citizen or a qualified alien under the federal Immigration and Nationality Act. Please check which box applies to you.

◆ For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

OR

I am a qualified alien under the federal Immigration and Nationality Act. **I am attaching a front and back copy of my USCIS documentation.** (example permanent resident card).

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Please Print Name (first, middle, last)

Client Signature

Date of Signature / Enrollment

Client Date of Birth

Cervical Diagnostic Enrollment / Follow Up and Treatment Plan

First Name	Initial	Last Name	Date of Birth / /
<input type="checkbox"/> Client enrolled for diagnostic testing <input type="checkbox"/> Client previously enrolled for screening services		Date of Cervical Screening reported in Section 1 / / Date of HPV Testing reported in Section 1 / /	

SECTION 1 Screening Test

SECTION 2 Diagnostic Workup - to be completed by the provider performing work up

Clinic Information	Referral Information	Pap Test Finding	Recommendations	Allowable for Reimbursement
SECTION 1: Screening - to be completed by the provider who initiated/completed Section 1 Date _____ Name and Address of Clinic initiating/completing SECTION 1 (do not abbreviate clinic name) <input type="checkbox"/> Client Referred to another provider who will take over care. Referral Clinician Information - clinician name, clinic name, city name (do not abbreviate clinic name) Date _____	<input type="checkbox"/> Negative/Benign <input type="checkbox"/> ASC-US, LSIL 21-24 persistent 24 mo <input type="checkbox"/> ASC-H, AGC, HSIL 21-24 <input type="checkbox"/> ASC-US with +HPV ≥ 21 yrs <input type="checkbox"/> LSIL +HPV or LSIL Unknown HPV ≥30 <input type="checkbox"/> ASC-H ≥30 <input type="checkbox"/> HSIL ≥30 <input type="checkbox"/> AGC-Atypical endometrial cells ≥ 25 <input type="checkbox"/> AGC - All categories except atypical endometrial cells (if ≥35 yrs or at risk for endometrial neoplasia) <input type="checkbox"/> HPV + Only <input type="checkbox"/> Squamous Cell Carcinoma	Colposcopy with biopsy with visible suspicious cervical lesion Colposcopy with biopsy Colposcopy with biopsy <i>Immediate treatment is unacceptable</i> <i>Observation up to 24 mo</i> Colposcopy with biopsy Colposcopy with biopsy LSIL -HPV is acceptable Colposcopy with biopsy <input type="checkbox"/> Endometrial biopsy criteria: <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Obesity BMI _____ <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) <input type="checkbox"/> Other conditions leading to chronic anovulation Endometrial & Endocervical samplings Colposcopy with biopsy Treatment referral to OB/GYN	Colposcopy with Endocervical Sampling or Cervical biopsy Date of Service ___/___/___ Cotesting is preferred at 1 year Colposcopy with Endocervical Sampling or Cervical biopsy Date of Service ___/___/___ <input type="checkbox"/> Endometrial biopsy <i>Both procedures must be performed same day</i> <input type="checkbox"/> Endocervical sampling Date of Service ___/___/___ All three procedures must be performed on same day <input type="checkbox"/> Colposcopy with Endocervical Sampling or Cervical biopsy <input type="checkbox"/> HPV Testing <input type="checkbox"/> Endometrial biopsy Date of Service ___/___/___ Colposcopy with Endocervical Sampling or Cervical biopsy Date of Service ___/___/___ Complete Section 3	

Consultation*/Diagnostic Information	<input type="checkbox"/> Consultation	<input type="checkbox"/> 2 nd Opinion	Date of Service ___/___/___
<input type="checkbox"/> Colposcopy only; no lesion present (expect 98% of clients to have colposcopy with biopsy)			Date of Service ___/___/___
<input type="checkbox"/> Client refused recommended diagnostic work up of _____ (Initiate Client Informed Refusal form) Client made Informed Decision <input type="checkbox"/> Yes <input type="checkbox"/> No			

Check one:	Mark Final Diagnosis Date ___/___/___ or date of Pathology Report (Must include copy of Pathology Report)	
	<input type="checkbox"/> Normal/Benign/Inflammation <input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III Carcinoma In Situ <input type="checkbox"/> HPV/Condylomata/Atypia	<input type="checkbox"/> Invasive Cancer Staging: <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV <input type="checkbox"/> Unknown
	<input type="checkbox"/> Inconclusive Results Date ___/___/___ <input type="checkbox"/> Treatment Not Indicated	

SECTION 2: Diagnostic		Date of Completion ___/___/___
Name and Address of Clinic initiating/completing SECTION 2 (do not abbreviate clinic name)		

*Consultations can only be reimbursed if provider normally brings clients into the office for consultation.

Cervical Acronyms

ASC-US:	Atypical squamous cells - undetermined significance
LSIL:	Low-grade squamous intraepithelial lesions
ASC-H:	Atypical squamous cells - cannot exclude HSIL
HSIL:	High-grade squamous intraepithelial lesions
AGC:	Atypical glandular cells
AG-NOS:	Atypical glandular cells, not otherwise specified
HPV:	Human papillomavirus
LEEP:	Loop electrosurgical excision procedure

Important Information for Cervical Cytology Follow-Up

- This form reflects **allowable reimbursement** based on the 2012 American Society for Colposcopy and Cervical Pathology (ASCCP) Consensus Guidelines and the recommendations of the Every Woman Matters (EWM) Medical Advisory Committee to deliver the most cost effective public health program.
- **Every Woman Matters Program is following the:**
 - 2012 ASCCP Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities.
 - 2012 ASCCP Consensus Guidelines for the Management of Women with Cervical Histological Abnormalities.
- The program and the EWM Medical Advisory Committee encourages providers to review the guidelines.
 - See the Cervical Protocols Section in the EWM Program Manual for the **algorithms** of the 2012 ASCCP Consensus Guidelines.
 - See the ASCCP website, www.asccp.org, for the **algorithms** and the article regarding the 2012 ASCCP Consensus Guidelines.

Client Name: _____
Client DOB: ____/____/____

SECTION 3 Treatment (Treatment for CIN I Colposcopy Results only allowed when previous Pap is > HSIL)

Client referred to another provider who will take over care

Referral Clinician Information - *clinician name, clinic name, city name* _____ (do not abbreviate clinic name)

Consultation* Date ____/____/____ *To give client treatment options*
**Consultations can only be reimbursed if provider normally brings clients into the office for consultation.*

Treatment Regimen consist of _____ (cryotherapy, cone, LEEP, etc.)
 Date Treatment started/initiated ____/____/____ (date of surgery, chemotherapy, radiation, etc.)
Complete Treatment Funds Request form if client needs financial assistance

Client refused treatment (*Initiate Client Informed Refusal form*) _____ **Client made Informed Decision** Yes No
 Treatment recommended _____ Reason for refusal _____

SECTION 3: Treatment - to be completed by the provider who initiated/completed Section 3

_____ Date _____

Name and Address of Clinic initiating/completing SECTION 3 _____ (do not abbreviate clinic name)

SECTION 4 Surveillance / Follow Up

Pre-authorization for 6 Months Follow Up (Approved pre-authorization form must be attached to claim)

Any other situations that follow the 2012 ASCCP Consensus Guidelines not indicated on this form must have pre-authorization (i.e., HSIL result and ≤CIN I, request colposcopy with biopsy, endocervical sampling and cytology in six months.) The program averages less than 50 cases a year that would require pre-authorization.
• Before you contact EWM for pre-authorization, please check your request to confirm that it follows the 2012 ASCCP Consensus Guidelines.

History of Prior Cervical Screening, Diagnostic Tests, and Treatment

Last Pap Result/Finding _____	Date ____/____/____
Last HPV Result/Finding _____	Date ____/____/____
Last Colposcopy with biopsy Diagnosis _____	Date ____/____/____
Last Treatment _____	Date ____/____/____

According to 2012 ASCCP Consensus Guidelines Requested Date ____/____/____
 Estimated Date of Service ____/____/____

Facility _____ Clinician _____
 Attention _____ Provider Phone Number (____) _____
 Provider Fax Number (____) _____

If procedure approved, please indicate Date of Service and Results: (Check Procedure Requested)

<input type="checkbox"/> Cytology	Date ____/____/____	<input type="checkbox"/> Negative/Benign
<input type="checkbox"/> Pelvic Exam	Date ____/____/____	<input type="checkbox"/> Negative/Benign
<input type="checkbox"/> HPV Testing	Date ____/____/____	<input type="checkbox"/> Negative/Benign
<input type="checkbox"/> Colposcopy with Biopsy	Date ____/____/____	<input type="checkbox"/> Negative/Benign
<input type="checkbox"/> Endocervical Sample	Date ____/____/____	<input type="checkbox"/> Negative Benign
<input type="checkbox"/> Cold Knife Cone	Date ____/____/____	<input type="checkbox"/> Negative/Benign

When results are received for other than negative/benign for any of the above, refer to Section 1 & 2 of this form for further required follow up.

Program Staff Use ONLY

Request Approved Yes No EWM Fax: 1-402-471-0913

Program Signature _____
 Date of Signature ____/____/____ **Approval is good for six months after Date of Signature*

FORM INSTRUCTIONS

Instructions on how to complete the Cervical Diagnostic Enrollment / Follow Up and Treatment Plan:

- **Use this form for all:**
 - Abnormal Pap Test findings (*ASC-H, Low Grade and High Grade SIL, Squamous Cell Cancer, AGC*)
 - Suspicious Pelvic exams (*suspicious cervical lesion, polyp is not considered suspicious for cervical cancer if Pap is negative*)
 - Positive HPV
- **If client has never been enrolled and is now in need of diagnostic test(s):** Have client complete Pages 1 and 2 of the form.
- **If client was screened on the EWM Program OR if client was previously enrolled for diagnostic services only and is 40-74:** a) Have client complete **ONLY** the name, date of birth and address on the first page. b) if client is 21-39 and is enrolling for diagnostic services have client complete pages 1 and 2 of the form.
- This form reflects allowable reimbursement based on the 2012 American Society for Colposcopy and Cervical Pathology (ASCCP) Cervical and Histological Guidelines (*The link to ASCCP Guidelines may be found at www.dhhs.ne.gov/womenshealth/ewm/ewmproviders.htm or www.asccp.org*).
- This form reflects allowable reimbursement based on the recommendations of the EWM Medical Advisory Committee to deliver the most cost effective public health program.

How to Complete the Form:

- Enter the Client Name and Date of Birth located in gray shaded box above Sections 1 and 2.
- Enter the date of the cervical screening that you are reporting in Section 1.
- Please check the appropriate box in Section 1 that gives the Screening Results.
- Please follow across to the right of Section 1 to choose the appropriate Diagnostic Test(s) and final diagnosis in Section 2.
- Section 3 gives you Treatment options.
- Section 4 is for Surveillance and Follow Up.

SECTION 1: To be completed by the provider regarding screening test(s).

- If client is enrolling for diagnostic tests only, the abnormal screening test should be no more than 6 months prior to enrolling.
- Please check the box for appropriate Pap test result.
- Complete the gray shaded on the left side of the page for referral to another provider.
- Screening Provider needs to enter name and address of the clinic completing Section 1.
- After Section 1 is complete and there is no referral, proceed to Section 2.
- For a referral, complete the referral provider information and send this form with the client to the referral provider.

SECTION 2: To be completed by the provider regarding diagnostic test(s).

- Complete Section 2 by marking the box for the diagnostic test, consultation, second opinion, client refuses diagnostic work up, etc. Example: Pap result of ASC-H in Section 1, straight across to the right in Section 2 are the appropriate diagnostic tests for ASC-H Pap results. Check the box of the procedure/test.
- Mark Inconclusive Results in Section 2.
- Mark final diagnosis in Section 2. This needs to be completed before it is sent to EWM.
- If client returns for clinic visit to receive options for diagnostic procedure/test, Consultation, or 2nd Opinion, that is found to the right of "Consultation/Diagnostic Information."
- If client refused diagnostic work up, please initiate the Client Refusal Form, check Yes or No as to whether she made an informed decision, the procedure she refused and the reason why.
- Diagnostic Provider needs to enter name and address of the clinic completing Section 2.

SECTION 3: To be completed by the provider regarding treatment.

- Please check the appropriate box for referral to another provider and enter provider name and address.
- If there is a consultation prior to treatment to give client treatment options, please check the consultation box and the date of the consult.
- If you are the treating provider, please complete the treatment information.
- If client refused treatment, please initiate the Client Refusal Form, check Yes or No as to whether she made an informed decision, the procedure she refused and the reason why.
- Enter treatment and date (i.e. surgery, chemotherapy, radiation, etc.) was initiated/started.
- Treatment Provider needs to enter name and address of the clinic completing Section 3.

SECTION 4: To be completed by the provider regarding surveillance/follow up.

- Any other situations that fall under the 2012 ASCCP guidelines not indicated on this form must have prior approval.
- Before you contact EWM for pre-authorization, please check your request to confirm that it follows the 2012 ASCCP Guidelines.
- Report the client history of prior cervical screening, diagnostic tests, or treatment.
- Request preauthorization for 6 month follow up. Enter recommended follow up test according to 2012 ASCCP guidelines.
- Approval request section to be completed by program staff only.
- Report findings if negative or benign. For other results refer to Section 1 and/or 2 for further required follow up.
- If 2012 ASCCP Guidelines indicate cytology at 6 months and 12 months or HPV testing at 12 months, EWM will **ONLY** pay for HPV testing at **12 months**.