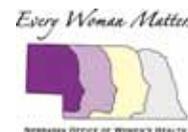


Cervical Diagnostic Enrollment, Follow Up & Treatment Plan for Women 21-74

Version: September 2014



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

PROVIDER NOTES:

- If client currently enrolled for screening services complete ONLY the name and date of birth on pages 3 and 4.
- Male clients - NOT eligible for screening or diagnostic procedures.

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.

INSTRUCTIONS: Please answer each question and PRINT clearly!

DEMOGRAPHICS

First Name: _____ Middle Initial: _____ Last Name: _____

Maiden Name: _____ Marital Status: Single Married Divorced

Birthdate: month / day / year Gender: Female Male Social Security #: _____ - _____ - _____

Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Preferred way of Contact? Home Work Cell
Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Yes I want to receive program information by email. Email: _____

In case we can't reach you: _____ Spouse Family/Friend
Contact person: _____ Relationship: Other _____

Phone: (_____) _____ Home Work Cell

Address: _____ City: _____ State: _____ Zip: _____

Are you of **Hispanic/Latina(o)** origin? Yes No Unknown Country of origin: _____

What is your **primary language** spoken in your home? English Spanish Vietnamese Other _____

What **race or ethnicity** are you?
(check all boxes that apply)

American Indian/Alaska Native Tribe _____
 Black/African American
 Mexican American
 White
 Asian
 Pacific Islander/Native Hawaiian
 Other _____
 Unknown

Are you a **Refugee**? Yes No DK* If yes, where from: _____

Highest level of **education** completed: 01 02 03 04 05 06 07 08 09 10 11 12
 13 14 15 16 16+ GED Don't Know Don't Want to Answer

How did you **hear about the program**: Doctor/Clinic Family/Friend Agency
 Newspaper/Radio/TV I am a Current/Previous Client Community Health Worker
 Other _____

INCOME & INSURANCE

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 for services received.

What is your **household income before taxes**? Weekly Monthly Yearly Income: \$ _____
 Please Note: Self employed are to use net income after taxes.

How many **people** live on this income? 01 02 03 04 05 06 07 08 09 10 11 12

Do you have **insurance**? Yes None/No Coverage If **yes**, is it: Medicare (for people 65 and over)
 Part A and B Part A only
 Medicaid (full coverage for self)
 Private Insurance with or without Medicaid Supplement
(please list) _____

BREAST & CERVICAL

1. Have **you** ever had any of the **following tests**?
Pap test Yes No DK* Most Recent Date ___/___/___ The result: Normal Abnormal DK*

Mammogram (breast x-ray) Yes No DK* Most Recent Date ___/___/___ The result: Normal Abnormal DK*

2. Have **you** ever had a **hysterectomy** (removal of the uterus)? No Yes DK*

2a. Was your **hysterectomy** to treat cervical cancer? No Yes DK*

3. Has your **mother, sister or daughter** ever had **breast cancer**? No Yes DK*

4. Have **you** ever had **breast cancer**? No Yes DK* When: ___/___/___

5. Have **you** ever had **cervical cancer**? No Yes DK* When: ___/___/___

*DK - Don't Know/Not Sure

Continue to Page 2 ----> ----> ---->

Informed Consent and Release of Medical Information

■ You must **read and sign this page** to be a part of the Every Woman Matters Program.

Version: September 2014

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
 - I can only receive cervical diagnostic tests if I am under the age of 40
 - I cannot be over income guidelines
 - If I have insurance, EWM will only pay after my insurance pays
 - I must be a female (per Federal Guidelines)
 - I will 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 breast cancer diagnostic tests.
- I know that if I am 40-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and 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/or cervical cancer screening, follow up exams, 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 Prevention and Control (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 Your Name (first, middle, last)

Your Signature

month / day / year

month / day / year

Date of Your Signature

Your Date of Birth

Completion of this form is required. Cervical Follow Up & Treatment Plan

CLIENT INFORMATION

First Name	MI	Last Name	Date of Birth
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PROVIDER INFORMATION

Clinic that initiated care:	Name	Address
Clinic that will take over care:	Name	Address

Date of Cervical Screening ___/___/___ Date of HPV Test: ___/___/___

SCREENING TESTS

DIAGNOSTIC WORKUP

Pap Test Finding	Preferred/Allowable for Reimbursement
<input type="checkbox"/> Cytology Negative	With cervical lesion <input type="checkbox"/> Colposcopy with biopsy Date of service ___/___/___
	HPV+ ages 30+ Repeat Co-testing @ 1 year (must re-enroll in State Pap Program) <input type="checkbox"/> Colposcopy with biopsy if HPV 16 or 18 positive Date of service ___/___/___
<input type="checkbox"/> Unsatisfactory	HPV Unknown or HPV- Repeat cytology in 2-4 months
	HPV+ Ages 21-29 Repeat cytology in 2-4 month, No HPV test allowed per guidelines
	Ages 30+ <input type="checkbox"/> Colposcopy with biopsy

Age	Pap Test Finding	Preferred/Allowable for Reimbursement
21-24	<input type="checkbox"/> ASC-US or LSIL	Repeat Cytology @ 12 Months (must re-enroll in State Pap Program)
	<input type="checkbox"/> ASC-H or HSIL	<input type="checkbox"/> Colposcopy with biopsy Date of service ___/___/___
25-74	<input type="checkbox"/> ASC-US	HPV Unknown Preferred: Do HPV testing Acceptable: Repeat cytology @ 1 year (must re-enroll in State Pap Program if <40)
		HPV- Repeat co-testing in 3 years (must re-enroll in State Pap Program if <40)
		HPV+ <input type="checkbox"/> Colposcopy with biopsy Date of service ___/___/___
	<input type="checkbox"/> LSIL	HPV- Preferred: Repeat Co-testing @ 1 year (must re-enroll in State Pap Program if <40) Acceptable: Colposcopy Date of service ___/___/___
		No HPV or HPV+ <input type="checkbox"/> Colposcopy with biopsy Date of service ___/___/___
	<input type="checkbox"/> ASC-H Regardless of HPV	<input type="checkbox"/> Colposcopy with biopsy Date of service ___/___/___
	<input type="checkbox"/> HSIL	<input type="checkbox"/> Colposcopy with biopsy OR Immediate LEEP Date of service ___/___/___
<input type="checkbox"/> AGC (initial workup)	**All Subcategories <input type="checkbox"/> Colposcopy + biopsy + ECC Date of service ___/___/___ <input type="checkbox"/> Endometrial biopsy (if ≥35 yrs or at risk for endometrial neoplasia*)	
	Atypical Endometrial Cells <input type="checkbox"/> Endometrial biopsy & ECC (if no endometrial pathology then) <input type="checkbox"/> Colposcopy with biopsy Date of service ___/___/___	
<input type="checkbox"/> Squamous Cell Carcinoma		Treatment referral to OBGYN-Complete Cervical Cancer Treatment Section
<input type="checkbox"/> Consultation <input type="checkbox"/> 2nd Opinion (only reimbursed if provider normally brings clients into the office for consultation)		Date of service ___/___/___

***This includes unexplained vaginal bleeding or conditions suggesting chronic anovulation**

REQUIRED!	Final Diagnosis Date or Pathology Report Date: ___/___/___
	Check One: <input type="checkbox"/> Normal/Benign Inflammation <input type="checkbox"/> CIN II <input type="checkbox"/> Invasive Cancer <input type="checkbox"/> HPV/Condylomata/Atypia <input type="checkbox"/> CIN III/Carcinoma in situ <input type="checkbox"/> CIN I <input type="checkbox"/> Treatment Not Indicated
	<input type="checkbox"/> Inconclusive Results Date ___/___/___ <input type="checkbox"/> Client refused diagnostic workup --Did client make informed decision? <input type="checkbox"/> Yes <input type="checkbox"/> No --Initiate Client Informed Refusal form
Clinic Name and Address	Date

Cervical Follow Up & Treatment Plan

First Name	MI	Last Name	Date of Birth month / day / year
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Cervical Cancer Treatment

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 Date ____/____/____ Client made Informed Decision Yes No
 Treatment recommended _____ Reason for refusal _____

Cervical Cancer Treatment - to be completed by the provider who initiated

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

Surveillance / Follow Up

6 month follow up must follow the 2012 ASCCP Guidelines
 Does this follow the 2012 ASCCP Consensus Guidelines? Yes No

History of Prior Cervical Screening, Diagnostic Tests and Treatment

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

Cytology & ECC @ 6 months Date ____/____/____ Negative/Benign
If CIN 2, 3 is identified at the margins of an excisional procedure for ages 25-74

Colposcopy with ECC Re-evaluation @ 6 months for ages 25-74 diagnosed with AIS when margins involved or ECC Positive
 Date ____/____/____ Negative/Benign

Colposcopy & Cytology Observation Date ____/____/____ Negative/Benign
@ 6 month intervals for 12 months for ages 25-29 with CIN2, 3 when no treatment has been done

Colposcopy & Cytology Observation Date ____/____/____ Negative/Benign
@ 6 month intervals for 2 years for ages 21-24 (no CIN 2 or 3 after ASCH, HSIL)

When results are received for other than negative/benign for any of the above, refer to page 3 for further required follow up.

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

Cervical Diagnostic Enrollment/Follow-up & Treatment Plan Instructions

EWM Medical Advisory Board Recommends that EWM follow the 2012 ASCCP Consensus Guidelines approved by the Center for Disease Control and Detection (CDC). ASCCP Guidelines can be found at: www.asccp.org/guidelines.

Enrollment must be used for:

Women 40+ who have had abnormal screening – if they are currently enrolled and have an abnormal screening, the provider only needs to complete page 3 of the form.

Women 21-29 who have had an abnormal Pap test within the last 6 month:

- a. Atypical Squamous Cells: Cannot Exclude High Grade SIL (ASC-H)
- b. Atypical Glandular Cells (AGC)
- c. High Grade SIL (HSIL)
- d. Squamous cell carcinoma

Women 30-39 who have had an abnormal Pap test within the last 6 month:

- a. Any one of the above a-d or b & c below.
- b. Atypical Cells of Undetermined Significance (ASC-US) with positive high risk HPV
- c. LSIL

Women 40-74 who have had an abnormal Pap test within the last 6 month to include all the above Pap results and/ or a Pelvic Exam suspicious for cervical malignancy within the last 6 months, if the client is entering the program for diagnostic services. If client has recently been screened on the program then only the diagnostic and treatment page need be completed

Providers review page 1 and 2 for completion by client (*if not completed client is considered not enrolled*):

Page 1 of the form must be completed with:

- Demographic information
- Income & insurance
- Breast & Cervical History

Page 2 must be completed with:

- Citizenship Status
- Alien Status (*client must provide a copy of their Permanent Resident Card*)
- Signature may not be after the date of service in order for services to be reimbursed

All clients must have:

- Current signature on file with EWM for 'Informed Consent and Release of Medical Information'.
- Any new client enrolling for diagnostic services must complete all information on pages 1 and 2 including a current signature and date of signature.
- Any client previously enrolled for screening services more than 12 months must also complete pages 1 and 2.

Providers must complete the following: (DO NOT SUBMIT the form UNLESS ALL OF THESE ITEMS ARE COMPLETE)

1. Make sure the client has completed page 1 and 2 with a signature/date of signature
2. Check the box with the abnormal findings
3. Check the box indicating corresponding diagnostic procedure done and date
4. Check the final diagnosis and date of diagnosis
5. Attach all documents if appropriate (copies of Pap report & pathology report)
6. Indicate type of treatment if client has cancer diagnosis
7. Fill in the clinic name

6 Month Surveillance and Follow Up (Women 40-74):

1. 6 month follow up for clients according to 2012 ASCCP Guideline on Page 4.
2. Client Must be enrolled
3. Preauthorization NOT needed

CRITICAL REMINDERS:

- **NO** old diagnostic forms will be accepted
- Diagnostic procedures must correspond with screening results
- Consultation can only be reimbursed if provider normally brings clients in the office for consultation
- Diagnostic office visit in accordance with the Program Guidelines (see page 25 of the 2014 Women's & Men's Health Provider Contract Manual found at: http://dhhs.ne.gov/publichealth/Documents/EWM_Manual.pdf).