

# Enrollment and Screening Information for Every Woman Matters Program & Nebraska Colon Cancer Screening Program

to be used in clinics for **NEW** Enrollments **ONLY**

## Breast & Cervical Cancer Screening

Services covered according to guidelines for **Women ages 40-74**

- Clinical Breast Exam (CBE)
- Mammograms
- Pelvic exam and Pap test

## Cardiovascular & Diabetes Screening

Services covered according to guidelines for **Women ages 40-74**

- Blood Pressure check
- Cholesterol check
- Blood Sugar (glucose) check

**Colon Cancer Screening** - you will receive a letter if you are eligible for colon cancer screening services

Services covered according to guidelines for **Nebraska Men and Women 50-74**

- Fecal Occult Blood Test (FOBT) for home testing; or
- Colonoscopy - if eligible

## Preventive Health Services

Services covered for **All clients**

- Health and Wellness information
- Referral to quit tobacco use - Nebraska Tobacco Quitline - 1.800.784.8669 or QuitNow.ne.gov



You are **NOT** eligible for the Every Woman Matters (EWM) Program or the Nebraska Colon Cancer Screening Program (NCP) services if you are:

- Under the age of 40 (EWM)
- Under the age of 50 (NCP)
- Over the age of 74
- Not a citizen or do not have a permanent residency card
- Have Medicaid, Medicare Part A and B or HMO (Health Maintenance Organization) insurance
- Over income guidelines (*income guidelines found at [www.dhhs.ne.gov/womenshealth/ewm](http://www.dhhs.ne.gov/womenshealth/ewm)*)

Be Active ~ Be Healthy

# Welcome

## to the Every Woman Matters Program and the Nebraska Colon Cancer Screening Program

As a client, you have access to quality health care services, education and information to help you make healthy lifestyle choices for personal wellness. **To take part in the program services you must remember the following:**

### ALL CLIENTS:

- Complete pages 3-8.
  - All gray shaded areas must be filled out.
  - You will not be enrolled unless these pages are completed.
- Make your appointment with a contracted provider.
  - If you choose a provider that is not contracted with the program(s), your services will not be paid for.
  - A listing of contracted providers can be found at: [www.dhhs.ne.gov/womenshealth/ewm](http://www.dhhs.ne.gov/womenshealth/ewm).
- Take this entire form with you to your appointment and give to your provider.
- Talk to your provider about what exams/tests they will be doing.
  - Exams/tests listed in this packet are the only services that will be paid for.

**Every Woman Matters Program (40-74)**  
**(WOMEN)**

**Nebraska Colon Cancer  
Screening Program (50-74)**  
**(MEN and WOMEN)**

### **If a mammogram is ordered:**

- ❖ Your provider will give you an EWM Mammography Order Form.
- ❖ Take the EWM Mammography Order Form with you to your mammogram appointment.

Eligibility for colon cancer screening is based upon your personal and family history. A nurse within the central office will review this form once we receive it. You will be notified from the central office once you have been approved for colon cancer screening services under the Nebraska Colon Cancer Screening Program.

### **Be sure your heart is healthy:**

- ❖ Come to your appointment fasting.
  - ❖ Fasting means that you do not eat or drink anything besides water for 9 (nine) hours before your exams.
  - ❖ Fasting will give correct results for the bloodwork.

- You must **read pages 3-4** to be a part of the Every Woman Matters Program and Nebraska Colon Cancer Screening Program. **You are NOT eligible for enrollment until page 4 is signed and dated.**

## EVERY WOMAN MATTERS (WOMEN)

- ❖ I want to be a part of the **Every Woman Matters (EWM) Program**. I know:
  - ❖ I must be between 40 and 74 years of age to receive services
  - ❖ 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 40-74 years of age I may be eligible for full screening services under the EWM Program based upon the US Preventive Services Task Force and Program Guidelines.
- ❖ 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 will only be eligible for these services based upon the US Preventive Services Task Force and Program Guidelines.
- ❖ 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.

## NEBRASKA COLON CANCER SCREENING PROGRAM (MEN and WOMEN)

- I want to be a part of the **Nebraska Colon Cancer Screening Program (NCP)**. I know:
  - I must be between 50 and 74 years of age to receive services (*there are no exceptions*)
  - I cannot be over income guidelines
  - I cannot have Medicaid, Medicare Part B, or an HMO
  - I must re-enroll in NCP every year
  - I must have a primary care doctor listed
  - I can notify NCP if I do not wish to be a part of this program anymore
  - I must be a Nebraska resident
- If I am eligible to participate, I understand that NCP will look at my health history and tell me what colon cancer screening test I am eligible for.
- Based upon my health history and what type of test I am eligible for, I know that NCP may provide me with a Fecal Occult Blood Test (FOBT) kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive an FOBT **from the program** and have a positive test, it may be followed up with a colonoscopy.
  - If I receive a colonoscopy through NCP I understand that I will be asked to pay 10% of the cost.
  - I understand that my payments will help others with colonoscopy costs through NCP.
- I will talk with my health care provider about the screening test(s) for colon cancer and understand possible side effects or discomforts.
- I will talk with the clinic about how I am going to pay for any tests or services that are not paid by NCP.
- I understand that NCP does not pay for treatment if I am diagnosed with colon cancer. NCP staff will assist me in finding treatment resources.

# *Informed Consent and Release of Medical Information*

(Continued)

Version: July 2013

- ◆ I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM/NCP 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/NCP, 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/NCP.
- ◆ To assist me in making the best health care decisions, EWM/NCP 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/NCP. 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/NCP 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/NCP 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

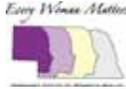
Client Date of Birth

# Every Woman Matters & NE Colon Program Enrollment

\*To use this form you must be 40-74

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.

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/ewm  
www.dhhs.ne.gov/crc

July 2013

## CLIENTS:

- Read, fill out, sign and date Pages 3-8.  
*All gray shaded areas **must** be filled out. You will **not** be enrolled unless these pages are completed.*

## PROVIDERS:

- Be sure that all information on Pages 3-8 are completed by the client.
- Complete Page 9 for screening services.
- Read Page 10 for helpful information on Clinical Practice/Reimbursement Reminders.
- Give the client Pages 11 and 12 once heart health screenings are recorded and discussed with client.

### FOR COLON CANCER SCREENING PROGRAM (Nebraska women and men 50-74 ONLY):

- Client is not eligible for colon cancer screening services until the forms are returned to the central office and reviewed. The client will be notified as to eligibility for the Nebraska Colon Cancer Screening Program and which colon test the client is eligible for. Clients must have a primary care doctor. Results of the testing will be sent to both the client and provider.

<b>First Name</b>		<b>Middle Initial</b>	<b>Last Name</b>		<b>Maiden Name</b>	<b>Birthdate</b> / /
<b>Gender</b> M / F	<b>Social Security #</b>		<b>Address</b>			
<b>City</b>			<b>County</b>	<b>State</b>	<b>Zip</b>	
<input type="checkbox"/> Please check box if you would like to receive client newsletter and/or program updates on your email.						
<b>Email Address</b>						
<b>Home Phone</b> ( ) ( )		<b>Work Phone</b> ( ) ( )		<b>Cell Phone</b> ( ) ( )		
<i>In case we can't reach you:</i> Contact person: _____ Relationship: _____ Phone: ( ) _____ Address: _____ City: _____ State: _____ Zip: _____				<b>How did you hear about the program?</b> <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 _____		
<b>What race or ethnicity are you?</b> <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				<b>Highest grade in school you completed: circle one</b> <b>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+</b>		
				<b>Are you of Hispanic/Latina origin?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Country of origin</b> _____		
				<b>What is your primary language?</b> <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>						
<b>What is your household income before taxes?</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <b>Income: \$</b> _____ <input type="checkbox"/> Yearly				<b>Do you have:</b> <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) _____		
<b>Please Note:</b> Self employed are to use net income after taxes.				<b>Is your insurance an HMO?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (An HMO is a health maintenance organization)		
<b>How many people live on this income?</b>						

**In order for EWM/NCP to pay for your services, you *MUST* complete all gray shaded areas.**

**BREAST & CERVICAL: FAMILY & PERSONAL HISTORY (ONLY women need to answer these questions)**

Has your *mother, sister or daughter* ever had breast cancer? No Yes Don't Know  
Have you ever had breast cancer? No Yes Don't Know  
Have you ever had a hysterectomy (*removal of the uterus*)? No Yes Don't Know  
Was it to take care of cancer? No Yes Don't Know When: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Have you ever had any of the following tests?:**

Pap test Yes No Don't Know Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
What did your doctor say about your exam? \_\_\_\_\_ Was your exam: Normal Abnormal

Mammogram (breast x-ray) Yes No Don't Know Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
What did your doctor say about your exam? \_\_\_\_\_ Was your exam: Normal Abnormal

**COLON CANCER: FAMILY & PERSONAL HISTORY**

How many 1st degree relatives, excluding yourself, (*parents, brothers, sisters, children*) have been told they have colon cancer or rectal cancer? 0 1 2 3+ Don't Know  
How many of those family members with colon cancer were under the age of 60? 0 1 2 3+ Don't Know  
How many 1st degree relatives, excluding yourself, (*parents, brothers, sisters, children*) have been told they have polyps in the colon? 0 1 2 3+ Don't Know  
How many of those family members with polyps were under the age of 50? 0 1 2 3+ Don't Know  
How many 1st degree relatives, excluding yourself, (*parents, brothers, sisters, children*) have been told they have other types of cancer? 0 1 2 3+ Don't Know  
What kind of cancer did they have? \_\_\_\_\_

**Have you ever had any of the following tests?:**

Fecal Occult Blood Test Yes No Don't Know Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
What did your doctor say about your exam? \_\_\_\_\_ Was your exam: Positive Negative

Colonoscopy Yes No Don't Know Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
What did your doctor say about your exam? \_\_\_\_\_ Were polyps removed? Yes No Don't Know

Sigmoidoscopy Yes No Don't Know Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
What did your doctor say about your exam? \_\_\_\_\_ Were polyps removed? Yes No Don't Know

Double Contrast Barium Enema (DCBE) Yes No Don't Know Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
What did your doctor say about your exam? \_\_\_\_\_

Have you ever been told by a doctor, nurse, or other health professional that you have had:  
Crohns Disease Yes No Don't Know  
Familial Adenomatous Polyposis (FAP) Yes No Don't Know  
Hereditary Non Polyposis Colorectal Cancer (HNPCC) Yes No Don't Know  
Inflammatory Bowel Disease (IBD) Yes No Don't Know  
Ulcerative Colitis Yes No Don't Know

Are you currently under a doctor's care for any of the above conditions? Yes No Don't Know

Within the last **30 days** have you had bleeding from the rectum? Yes No Don't Know  
What did your doctor say about your rectal bleeding? \_\_\_\_\_

Have you ever been told that you have had polyps in the colon? Yes No Don't Know  
What type of polyps did you have? \_\_\_\_\_ How many polyps did you have? \_\_\_\_\_

Have you ever been told that you have had colon or rectal cancer? Yes No Don't Know  
If yes, when were you diagnosed? \_\_\_\_/\_\_\_\_/\_\_\_\_

**My primary care doctor is: (please print)** \_\_\_\_\_

**Name of Clinic** \_\_\_\_\_ **City** \_\_\_\_\_ **Phone** \_\_\_\_\_

# Health Assessment

*In order for EWM/NCP to pay for your services, you **MUST** complete all gray shaded areas.*

<p><b>(1) Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(2) Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(3) Have you ever been told by a doctor, nurse, or other health professional that you have diabetes?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Gestational (pregnancy) Diabetes only <input type="checkbox"/> Refused/Don't want to answer
<p><b>(4) Has a doctor, nurse, or other health professional ever told you that you had any of the following: heart attack (also called myocardial infarction), angina, coronary heart disease or stroke?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(5) Has your father, brother, or son had a stroke or heart attack before age 55?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(6) Has your mother, sister, or daughter had a stroke or heart attack before age 65?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(7) Has either of your parents, your brother or sister, or your child ever been told by a doctor, nurse, or other health professional that he or she has diabetes?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(8) Are you taking any medication prescribed by your doctor, nurse or health professional for your high cholesterol?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(9) Are you taking any medication prescribed by your doctor, nurse or health professional for your high blood pressure?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(10) Are you taking any medication prescribed by your doctor, nurse or health professional for your Diabetes?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(11) Do you now smoke cigarettes?</b></p>	<input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused/Don't want to answer
<p><b>(12) Not counting decks, porches, or garages, during the past 7 (seven) days, on how many days did someone other than you smoke tobacco inside your home while you were at home?</b></p>	____ Number of days <input type="checkbox"/> None <input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Refused/Don't want to answer

<b>Fruits and Vegetables</b>				
<p><b>(13) How many servings of fruits did you eat yesterday? This includes fresh, frozen, canned, or dried, but would not include fruit juice.</b></p>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	
<p><b>(14) How many servings of 100% fruit juice did you drink yesterday? This would not include any juice with the word drink or cocktail on the label, Hi-C, Tang, or Sunny Delight.</b></p>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	
<p><b>(15) How many servings of vegetables did you eat yesterday? This includes fresh, frozen, canned, dried, as well as any vegetable juice or soups &amp; stews made with vegetables. Also includes potatoes, salad &amp; salsa.</b></p>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	

7 Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please continue to Page 8*

### Physical Activity

- (16) In a usual week, how many days are you active for at least 10 minutes at a time?  
Active means brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate.  0  1  2  3  
 4  5  6  7
- (17) On days when you are active, how much total time are you active each day? \_\_\_\_\_ hours \_\_\_\_\_ minutes
- (18) Do you experience any chest discomfort or shortness of breath when you walk briskly?  No  Yes  Don't Know
- (19) Has your health care provider ever told you not to increase your physical activity?  No  Yes  Don't Know
- (20) Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms?  No  Yes  Don't Know
- (21) Have you ever been told by a doctor or health care provider that you have arthritis, lupus, or fibromyalgia?  No  Yes  Don't Know

### Other Important Questions Related to Your Health

- (22) During the past month have you often been bothered by feeling down, /depressed or hopeless?  No  Yes
- (23) During the past month have you often been bothered by little interest/pleasure in doing things?  No  Yes
- (24) During the past month has a doctor or health care provider ever told you that you have depression?  No  Yes
- (25) Are you currently taking medication for depression?  No  Yes
- (26) When was the last time you had more than four alcoholic drinks in one day?  Never  In past 3 months  
 Over 3 months ago
- (27) Do you feel safe in your current relationship?  No  Yes  N/A
- (28) Have you been hit, kicked, punched or otherwise hurt by someone in the past year?  No  Yes
- (29) Is there a partner from a previous relationship who is making you feel unsafe now?  No  Yes
- (30) How often do you use seat belts when you drive or ride in a car?  Always  Nearly Always  
 Sometimes  Seldom  Never
- (31) During the past 12 months, have you had a flu shot?  No  Yes  Don't Know  
If not, why? \_\_\_\_\_
- (32) Have you had a pneumonia shot?  No  Yes  Don't Know
- (33) How long has it been since you last visited a dentist or a dental clinic for any reason?  Within past year  
 Within past 2 years  
 Within past 5 years  
 5 or more years ago
- (34) When was the last time you had your eyes examined by any doctor or eye care provider?  Within past month  
 Within past year  
 Within past 2 years  
 2 or more years ago  
 Never
- (35) Please list all prescribed medications you take on a regular basis: \_\_\_\_\_
- (36) Did you take your full dose(s) today?  No  No, I'm fasting  
If not, why?  Yes  Don't Know  
 Cost  Side Effects  
 Sample/Supply ran out  
 Other \_\_\_\_\_
- (37) Please list all over the counter medicines, vitamins or herbal supplements you take on a regular basis: \_\_\_\_\_



**STOP here!** Have you filled out all the gray areas of pages 3-8?  
In order for EWM/NCP to pay for your services, you **MUST** complete pages 3-8.



## Reimbursable Required Risk Reduction Counseling:

- Entire packet must be completed and reviewed
- Preventive health behaviors/risk factor reduction
- Physical activity
- BMI / Weight Management
- Nutrition
- Tobacco cessation

Client Referred to Statewide Quitline at 1-800-QUIT-NOW

Colon Cancer Screening discussed with client

## Clinician: IMPORTANT for PAYMENT

- **Completion of this box is equivalent to submitting a claim for Risk Reduction Counseling.**
- You **MUST** initial in order to be reimbursed.

Total time spent: \_\_\_\_\_

10 minutes       20 minutes       30 minutes

Mid-Level Initials \_\_\_\_\_       Physician Initials \_\_\_\_\_

## General Clinical Services for All Clients

Height: (with shoes off) \_\_\_\_\_ / \_\_\_\_\_ feet/inches \_\_\_\_\_ Refused

Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ Refused

Waist Circumference: \_\_\_\_\_ inches \_\_\_\_\_ Refused

Blood Pressure (1): \_\_\_\_\_ / \_\_\_\_\_ mm Hg \_\_\_\_\_ Refused

Blood Pressure (2): \_\_\_\_\_ / \_\_\_\_\_ mm Hg \_\_\_\_\_ Refused

**2 Blood Pressure readings *MUST* be taken at this visit.  
CDC & JNC VII Guidelines *REQUIRE* 2 blood pressures**

## Clinical Breast Exam

### Mark finding:

- Negative/Benign
- Suspicious for **BREAST** Malignancy  
*Immediate follow up is required beyond mammography*
- Not Performed (*list reason*) \_\_\_\_\_

## Mammography

### Recommended Reimbursement as follows:

- **40-74 every 2 years**

### Mark if:

- Bi-ennial mammogram       Follow up mammogram  
*Give client Mammography Order Form*
- Mammogram not ordered *If not performed, mark or list reason:*
  - Not age appropriate
  - Other \_\_\_\_\_

## Pelvic Exam

### Mark finding:

- Negative/Benign       Visible Suspicious **CERVICAL** lesion
- Not Performed (*list reason*) \_\_\_\_\_

## Screening Pap

**PROGRAM POLICY:** Client is **ONLY** eligible **EVERY THREE YEARS** or **EVERY FIVE YEARS** with HPV co-testing.

*EWM Medical Advisory Committee strongly recommends liquid-based Pap testing.*

- Pap test performed** - place red & white EWM sticker on lab requisition  
*(HPV co-testing or reflexive HPV for ASC-US only)*
- Pap test not ordered** *If not performed, mark or list reason:*
  - Client not due based on national guidelines
  - Hysterectomy (with cervix removed) not due to cervical cancer
  - \_\_\_\_\_

## Recommendation for Surveillance/Follow-Up

### Pap can **ONLY** be performed for one of the reasons below:

- Most recent Pap test was abnormal per 2012 ASCCP Guidelines
- Compromised Immune System (from HIV infection, organ transplant, chemotherapy or chronic steroid use)
- Intrauterine DES exposure
- History of Invasive Cervical Cancer
- Pap test performed** - place red & white EWM sticker on lab requisition
- HPV Testing ONLY** for 12 months surveillance for diagnosis of ASC-US HPV+ - CINI (**NO CYTOLOGY**)

***This form expires on May 31, 2014***

**\*\*MUST be an approved contracted provider to receive reimbursement.**

**\*\*For the office visit to be paid, the client *MUST* have breast or cervical cancer screening services.**

Date of Service for Office Visit \_\_\_\_\_

Clinician Name (*Please print full name - do not abbreviate*) \_\_\_\_\_

Clinic Name (*Please print full name - do not abbreviate*) \_\_\_\_\_

City \_\_\_\_\_

*Clinical Practice Guidelines on Back*

# Clinical Practice/Reimbursement Reminders

For further information on guidelines, reimbursement, and program policies and procedures, please go to: [www.dhhs.ne.gov/womenshealth/ewm](http://www.dhhs.ne.gov/womenshealth/ewm)

## General Health

- CDC & JNC VII Guidelines REQUIRE 2 blood pressure readings to be taken at each visit
- Reported height and weight to client and discussed if this was a healthy weight for the client

## Breast Health

- Annual Clinical Breast Exam (CBE) is expected for all clients
- A CBE must accompany all mammography
- Screening mammography reimbursed only for women ages 40-74
- Bi-ennial mammography (every 2 years) is reimbursed for women ages 40-74
- Computer Aided Detection (CAD) and Magnetic Resonance Imaging (MRI) is NOT covered

## Cervical Health

- Pelvic exam must be in conjunction with a Pap test and/or CBE
- Reimbursement based on the 2012 American Society for Colposcopy and Cervical Pathology (ASCCP) Cervical and Histological Guidelines (See [www.asccp.org](http://www.asccp.org)) as recommended by EWM Medical Advisory Committee to deliver the most cost effective public health program

## Colon Health

- Reimbursement by NCP is based upon pre-approval
- **Digital Rectal Exam (DRE)** and **in office FOBT** are not appropriate screening tools for colon cancer screening
- Any positive results on a FOBT kit requires a follow-up colonoscopy according to CDC

## Lifestyle Health

- Discussed nutritional intake and offered suggestions for improvement
- Inquired about physical activity level and provided examples of how physical activity can be added in to daily activities

## Preventive Health

- Assessed client has received timely and age appropriate vaccinations and other health system checks

## Behavioral Health

- Reviewed depression risk and/or depression medications with client
- Inquired about relationship safety of client

## Risk Reduction Counseling

- Counseled the client on the interpretation of the test results and the recommended treatment, including a review of all results, medications ordered, lifestyle modifications, interventions recommended, and accessible community resources.
- Gave client the “Heart Health Results and Information” (pages 11 and 12). These two pages give the client and health care provider a place to write down the client’s CVD/Diabetes screening results. This is also a place for the client and health care provider to talk about goals to improve the client’s overall health.

## Smoking Health

- All clients who smoke must be referred to the Nebraska Quitline
- Assessed client’s readiness for smoking cessation or willingness to address second hand smoke issue

# Your Heart Health Screening Results and Information

Talk with your health care provider about your screening results before the end of your visit.

Discuss what they mean for you and any changes you can make for a heart healthier life.

**Blood Pressure:** Blood pressure is the force of your blood pushing against the walls of your arteries. Your blood pressure is at its highest when your heart beats, pumping blood. This is the top number of your blood pressure reading. It is called your **systolic** (sis-ta-lik) blood pressure.

When your heart is at rest, between beats, your blood pressure falls. This is the bottom number of your blood pressure reading. It is called your **diastolic** (di-uh-sta-lik) blood pressure.

**Healthy Range:**

-Systolic number is 120 or below

-Diastolic number is 80 or below

**My Blood Pressure is:** \*Provider should take two readings at this visit as required by Program Guidelines.

**1<sup>st</sup> Blood Pressure Taken:** \_\_\_\_\_ / \_\_\_\_\_  
(Systolic) (Diastolic)

**2<sup>nd</sup> Blood Pressure Taken:** \_\_\_\_\_ / \_\_\_\_\_  
(Systolic) (Diastolic)

High blood pressure usually has no symptoms. If one reading is in the high range, there is a chance that you may develop high blood pressure. Have it checked often.

Systolic

Diastolic

180 & above

110 & above

160-179

100-109

140-159

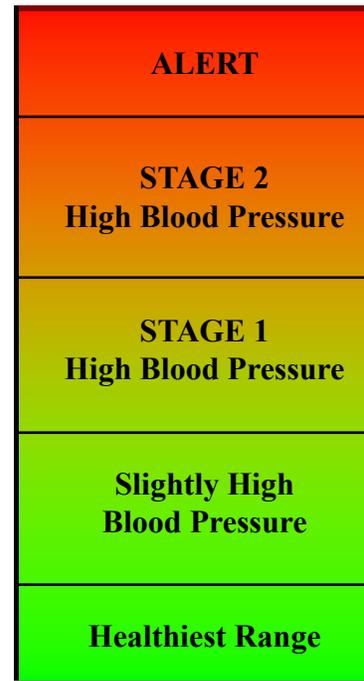
90-99

120-139

80-89

120 & below

80 & below



Client: Please take this page home with you.

**Body Mass Index (BMI)** - BMI is the measure of your weight compared to your height. If your BMI is 25 or higher, you could be more at risk for heart disease.

My Height is: \_\_\_\_\_

My Weight is: \_\_\_\_\_

My BMI is: \_\_\_\_\_

<b>Obese BMI of 30 or Higher</b>
<b>Overweight BMI 25 to 29</b>
<b>Healthy Weight BMI 18 to 24</b>

<b>35 inches or more</b>
<b>34 inches or less</b>

**Waist Circumference:** The measurement around your middle, just above your hipbones.

Women: To reduce your risk of heart disease the distance around your waist should be 35 inches or less.

Men: To reduce your risk of heart disease the distance around your waist should be 40 inches or less.

**My Waist Circumference is:** \_\_\_\_\_

<b>40 inches or more</b>
<b>39 inches or less</b>

*Your cholesterol and diabetes screening results may not be ready today.*

*Talk to your provider about when your results will be ready and how to understand those results.*

**Total Cholesterol**

Cholesterol is a fatty substance that is made by your body. You can also find it in foods that come from animals, like meat, eggs, and cheese.

**My Total Cholesterol is:** \_\_\_\_\_

<b>Alert 400 or higher</b>
<b>High 240 or higher</b>
<b>Borderline High 200-239</b>
<b>Healthiest Range</b>

**High  
60 or Higher**

**Healthiest  
Range  
40-59**

**Alert  
Below 40**

**HDL Cholesterol**

HDL cholesterol is known as “good” cholesterol, because high levels of HDL seem to protect against heart attack. Low levels of HDL increase the risk of heart disease.

**My HDL Cholesterol is:** \_\_\_\_\_  
**Healthy Range: 40 or above**

Provider: Please review this page with your client.

# Your Heart Health Screening Results and Information

(Continued)

<p style="text-align: center;"><b>Diabetes</b></p> <p>Type 2 diabetes begins when your body can't use insulin as it should. Keeping active and eating a healthy diet can help prevent diabetes and lower your risk for heart disease and stroke. Screening for diabetes is done with a fasting blood glucose test.</p> <p><b>My Blood Glucose is:</b> _____</p> <p><b>Healthy Range: Below 100</b></p>	<table style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #ff0000; color: white;"> <td style="padding: 5px;"><b>Alert 375 or Higher</b></td> </tr> <tr style="background-color: #ffa500;"> <td style="padding: 5px;"><b>Diabetes 126 or Higher</b></td> </tr> <tr style="background-color: #90ee90;"> <td style="padding: 5px;"><b>Pre-Diabetes 100-125</b></td> </tr> <tr style="background-color: #00ff00;"> <td style="padding: 5px;"><b>Healthy Range 100 or Lower</b></td> </tr> </table>	<b>Alert 375 or Higher</b>	<b>Diabetes 126 or Higher</b>	<b>Pre-Diabetes 100-125</b>	<b>Healthy Range 100 or Lower</b>
<b>Alert 375 or Higher</b>					
<b>Diabetes 126 or Higher</b>					
<b>Pre-Diabetes 100-125</b>					
<b>Healthy Range 100 or Lower</b>					

<p style="text-align: center;"><b>Screening Results Not Ready Today?</b></p> <p>Talk with your provider about when to call in or if you will receive your results in the mail.</p> <p>Date to Call: _____</p> <p>Phone Number: _____</p> <p>_____ Yes, I will receive my results in the</p>
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***After you discuss your screening results and personal action plan with your provider, take this page with you. Take action for a heart healthy life and remember small changes can make a big difference!!***

## Congratulations for making time for yourself and your health!

Routine screening exams are a key to a healthy life. Other keys to living a healthy life include: following a healthy eating plan, being active regularly, losing or maintaining a healthy weight, and not smoking. Also, taking medications as prescribed by your health care provider is important.

### ***What's Your Personal Action Plan to Help You Be Healthier?***

**Physical Activity:** People who do not get much physical activity have an increased risk for heart disease. Regular activity has many benefits such as helping people quit smoking, lose weight, reduce stress, lower blood pressure and increase HDL (good) cholesterol. Being active on most days of the week for 30 to 60 minutes helps your heart most.

***My Physical Activity Plan:***

- \_\_\_\_\_ Make a list of physical activities I like best and talk to my provider about a plan that's best for me.
- \_\_\_\_\_ Join an exercise group or find a "workout buddy" to keep me motivated.
- \_\_\_\_\_ Ask family and friends for support.
- \_\_\_\_\_ Start slowly and build up to at least 30 minutes a day on all or most days of the week. To start, I will aim for:
  - \_\_\_\_\_ 10 minutes total of walking or activity per day on 5-7 days a week
  - \_\_\_\_\_ 20 minutes total of walking or activity per day on 5-7 days a week
  - \_\_\_\_\_ 30 minutes total of walking or activity per day on 5-7 days a week
- \_\_\_\_\_ Other: \_\_\_\_\_

**Healthier Food Choices:** All of us could eat a little better than we do. Take an honest look at how many fruits and vegetables you are eating, how much fat is included in your diet and identify healthy eating habits you can change. Just getting one or two more fruits and vegetables a day can make a difference!

***My Healthy Eating Plan:***

- \_\_\_\_\_ Eat smaller portions of food. Keep my portions smaller than my fist.
- \_\_\_\_\_ Learn how to read food labels to help me choose healthy foods.
- \_\_\_\_\_ Eat 3 or more whole-grain foods every day.
- \_\_\_\_\_ Eat at least 5-9 servings of fruits and vegetables a day. To start, I will aim for:
  - \_\_\_\_\_ 1-3 servings of fruits and vegetables a day
  - \_\_\_\_\_ 4-6 servings of fruits and vegetables a day
  - \_\_\_\_\_ 7-9 servings of fruits and vegetables a day
- \_\_\_\_\_ Other: \_\_\_\_\_

**Tobacco Cessation:** Giving up smoking isn't easy. In fact, many people say it's like losing their best friend. But just one change-from smoker to non-smoker-can make a big difference in your health. The good news is, it's never too late to quit.

***My Tobacco Cessation Plan:***

- \_\_\_\_\_ Call the Nebraska Quitline at 1-800-QUIT-NOW for free personalized assistance.
- \_\_\_\_\_ Find out about local support groups or programs that help people stop smoking.
- \_\_\_\_\_ Find other things that give me pleasure that can take the place of smoking.
- \_\_\_\_\_ Choose a method for quitting smoking.
- \_\_\_\_\_ Set a quit date and stick to it. Date I plan to quit: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

*Free or low-cost community based activities which may be available in your area can be found at: [www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth)*