CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

Every Woman Matters — NEBRASKA Good Life. Great Mission. DEPT. OF HEALTH AND HUMAN SERVICES

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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

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.

PROVIDER NOTES:

- **Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.**
- If client is currently enrolled for screening services complete **ONLY** the name and date of birth on pages 3 and 4.
- Diagnostic form instructions may now be found online at **dhhs.ne.gov/ewmforms**

Please answer each question and PRINT clearly!

CONTACT INFORMATION

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

Maiden Name: _____ **Marital Status:** ❍Single ❍Married ❍Divorced ❍Widowed

Birthdate: _____/_____/_____ **Social Security #:** _____-_____-_____ **Birth place** _____
City and state or country of birth

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: _____

EMERGENCY CONTACT

Contact person: _____ **Relationship:** _____

Phone: (_____)_____ ❍Home ❍Work ❍Cell

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

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin?
❍Yes ❍No ❍Unknown

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:
❍<9th grade ❍Some high school
❍High school graduate or equivalent
❍Some college or higher ❍Don't know
❍Don't want to answer

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

HEALTH HISTORY

Have you ever had any of the following tests?:

Pap test ❍Yes ❍No ❍DK*
Most Recent Date ____/____/____
The result: ❍Normal ❍Abnormal ❍DK*

Have **you** ever had a **hysterectomy** *(removal of the uterus)*? ❍Yes ❍No ❍DK*
2a. Was your cervix removed? ❍Yes ❍No ❍DK*
2b. Was your **hysterectomy** to treat cervical cancer? ❍Yes ❍No ❍DK*

Have **you** ever had cervical cancer?
❍No ❍Yes ❍DK* When: _____/_____/_____

Mammogram ❍Yes ❍No ❍DK*
Most Recent Date ____/____/____
The result: ❍Normal ❍Abnormal ❍DK*

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

Have **you** ever had breast cancer?
❍No ❍Yes ❍DK* When: _____/_____/_____

**DK - Don't Know/Not Sure*

Continue to Page 2 ⇢ ⇢ ⇢

Finish the section below... read the consent... check a box... then sign & date and you're done!

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? ❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10 ❍11 ❍12

Do you have **insurance**?* ❍Yes ❍None/No Coverage

If **yes**, is it: ❍Medicare (for people 65 and over) ❍Part A only ❍Part A and B ❍Medicaid (full coverage for self) ❍Private Insurance with or without Medicaid Supplement ***(please list)***

***Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.**

Informed Consent and Release of Medical Information

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

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
  - If I am under the age of 40, I can *only* receive breast diagnostic tests.
  - 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.

CHECK ONE

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.

SIGN AND DATE

_____
Please Print Your Name (first, middle, last) Your Signature

_____/____/_____ _____/____/_____
Date Your Date of Birth

Cervical Follow-Up and Treatment Plan

*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

Name:	**First**	**MI**	**Last**	**DOB**
Provider information:	**Screening:** Clinic that initiated care	Name	City and Phone #	
	Diagnostic: Clinic that patient was referred to	Name	City and Phone #	

Instructions: Please send EWM this form along with Pap test and colposcopy results when diagnostic workup is complete. Must follow current ASCCP guidelines.

Pap results: Find the client's Pap test result below and mark the date of service for the Pap and procedure listed directly underneath.

If your client's procedure is NOT listed directly underneath their Pap result, it may not be reimbursable by our program. Call us to discuss.

Negative
Date _____

With cervical lesion
☐ Colposcopy with biopsy
Date of service:
____/____/____

HPV+ ages 30+
☐Repeat co-testing @1 year (must re-enroll in State Pap Program if under 40)
☐ Colposcopy with biopsy **IF HPV 16 or 18 positive**
Date of service:
____/____/____

Unsatisfactory
Date _____

HPV unknown or HPV-
Repeat cytology in 2-4 months.
Not eligible for colposcopy.

HPV+
Ages 21-29:
Repeat cytology in 2-4 months, no HBV test allowed per guidelines
Ages 30+
☐ Colposcopy with biopsy
Date of service:
____/____/____

ASC-US
Date _____

Ages 21-24:
Repeat Cytology in 12 months. Must re-enroll in the State Pap Program.
Not eligible for colposcopy

Ages 25-74:
HPV unknown:
Preferred: do HPV testing
Acceptable: Repeat cytology at 1 year

HPV negative:
Repeat co-testing in 3 years

HPV positive:
☐ Colposcopy with biopsy
Date of service:
____/____/____

LSIL
Date _____

Ages 21-24:
Repeat Cytology in 12 months. Must re-enroll in the State Pap Program. *Not eligible for colposcopy*

Ages 25-74:
HPV negative:
Preferred: Repeat co-testing in 1 year
Acceptable:
☐ Colposcopy
Date of service
____/____/____

HPV positive or no HPV:
☐ Colposcopy
Date of service
____/____/____

ASC-H
Date _____

☐ Colposcopy with biopsy

Date of service
____/____/____

HSIL
Date _____

Ages 21-24:
☐ Colposcopy with biopsy
Date of service
____/____/____

Ages 25-74:
☐ Colposcopy with biopsy OR
☐ immediate LEEP

Date of service
____/____/____

AGC
Date _____

All Subcategories:
☐ Colposcopy with biopsy + ECC and
☐ Endometrial biopsy*
Both to be done on the same day.
Date of Service
____/_____/_____

Atypical Endometrial Cells:
☐ Endometrial and endocervical Sampling.
Date of Service
____/_____/_____

If no endometrial pathology:
☐ Colposcopy
Date of Service
____/_____/_____

Sq. Cell Carcinoma

Date
___/___/____

Treatment referral to OB/GYN

Complete page 4 – cervical cancer treatment section.

*If ≥ 35 years or at risk for endometrial neoplasia. Includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.

☐ **Consultation or second opinion:** Physician: _____ Clinic Name:_____ Date of service:_____

Final Diagnosis:

This section must be completed before sending in. ★

Date of final diagnosis or pathology report:
____/____/_____

Check one:
☐ Inconclusive Results
☐ Normal/Benign Inflammation
☐ HPV/Condylomata/Atypia
☐ CIN I → ☐ Treatment not indicated
☐ CIN II ☐ CIN III carcinoma in situ
☐ Invasive Cancer

For CIN II and greater, complete pg 4: Cervical Cancer Treatment and Referral

Refusal:
☐ Client refused diagnostic workup
--Did client make informed decision?
☐ Yes ☐ No
--Initiate Client Informed Refusal Form

Clinic Name: **Date:**

- Fax to 402-471-0913 or mail to Every Woman Matters, PO Box 94817 Lincoln, NE 68509-4817
- **Call us with any questions at 1-800-532-2227.** ★ Print out forms online at www.dhhs.ne.gov/ewmforms
- **Instructions are no longer being printed along with the form.** They are now posted online at **www.dhhs.ne.gov/ewmforms**

Cervical Follow-Up and Treatment Plan

Women under age 40 who require cytology at 1 year as follow-up must enroll in the Nebraska State Pap Plus Program in order for this service to be covered.

CIN 2 or 3 with no margins involved: Repeat co-testing at 12 & 24 months.

Client information:	First Name	MI	Last Name	DOB

Cervical Cancer Treatment & Referral

Referral:	Client referred to _____ who will take over care. Clinician and clinic name and city
Consultation:	Consultation Date to give client options _____ Consultations can only be reimbursed if provider normally brings clients into the office for consultation.
Treatment:	Treatment regimen consists of _____(cryotherapy, cone, LEEP, surgery, chemo, radiation, etc) Treatment date _____
Refusal:	Cancer treatment refused date _____ Client made informed decision yes/no Reason for refusal:_____

6 Month Follow-up of Previous Abnormal Finding

Age 21-24	Age 25-29	Age 25-74
Prior history: Prior Pap test result: ☐ ASC-H ☐HSIL Date: _____	**Prior history*:** Prior Pap test date: _____ Results _____ Prior Colposcopy date: _____ Results _____ ***Must provide prior Pap/Colposcopy reports**	
Pap ASC-H, HSIL but no CIN 2 or 3 Colposcopy/Cytology at 6 month intervals for 2 years Date_____ Results _____	**CIN 2 or 3 with No treatment done** Observation – colposcopy and cytology at 6 month intervals for 12 months Date_____ Results _____	**CIN 2 or 3 with margins involved** Colposcopy and cytology with ECC Re-evaluated at 4-6 months Date_____ Results_____
CIN 2 or 3 with No treatment done Observation – colposcopy and cytology at 6 month intervals for 12 months Date_____ Results_____		
Name of Clinic	**City:**	**Date:**

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