BREAST DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 18-74

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

4/2022

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** pages 3 and/or 4.
- Diagnostic form instructions may now be found online at **dhhs.ne.gov/ewmforms**
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg73 and pg80 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

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

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

Gender: ❍Female ❍Transgender ❍Female to Male ❍Male to Female

Do you identify as: ❍Heterosexual ❍Lesbian ❍Bisexual ❍Gay

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

Address: _____ **Apt. #** _____

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

Home Phone: (_____)_____ **Work Phone:** (_____)_____ **Cell Phone:** (_____)_____

Preferred way of Contact?: ❍Home ❍Work ❍Cell **Is it okay to text your cell phone?** ❍Yes ❍No

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

OTHER CONTACT

Contact person: _____ **Relationship:** _____

Phone: (_____)_____ ❍Home ❍Work ❍Cell

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*
Previous/Prior Pap test Date ____/____/____
The result: ❍Normal ❍Abnormal ❍DK*

HPV test ❍Yes ❍No ❍DK*
Previous/Prior HPV test 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*
Previous/Prior Mammogram 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: _____/_____/_____

Continue to Page 2 ⇢ ⇢ ⇢

INCOME & INSURANCE

I may 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 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.

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. 4-111(1)(b), 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, 8 U.S.C. 1101 et seq., as such act existed on January 1, 2009, and is lawfully present in the United States. I am attaching a front and back copy of my USCIS documentation. **(for example, Permanent Resident Card or A-Number/Alien Registration Number)**

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 & DATE

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

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

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

Breast Follow-Up & Treatment Plan

Name:	**First**	**MI**	**Last**	**DOB**
Provider Information:	**Screening:** Clinic that initiated care	Name:	*City/Phone Number*	
	Diagnostic: Clinic that patient was referred to	Name:	*City/Phone Number*	

Instructions: Please send this form to EWM along with corresponding radiology and/or pathology reports when diagnostic workup is complete.

Ages 18-39

Screening History:

❍ **Clinical Breast Exam Suspicious for Breast Malignancy** Date: ____/____/____

Diagnostic Workup:

❍Surgical Consultation Date: ____/____/____
Physician: _____

- If CBE is suspicious, EWM encourages surgical consult **BEFORE** ultrasound

❍Breast Ultrasound Date: ____/____/____

- Preferred: Referral to surgeon for evaluation and to determine need for u/s
- Acceptable: Breast u/s ordered by Primary Care Provider if no surgeon available

❍Diagnostic Mammogram Date: ____/____/____

- **Client must be at least age 30 to have a Diagnostic Mammogram**
- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍Repeat Breast Exam Date: ____/____/____
❍Breast Biopsy type: _____ Date: ____/____/____
❍Breast MRI *for suspected Inflammatory Breast Cancer* Date: ____/____/____
❍Consultation/2nd opinion Date: ____/____/____
❍FNA OR ❍U/S-Guided Needle Aspiration Date: ____/____/____
❍Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Ages 40-74

Screening History:

❍ **Clinical Breast Exam Suspicious for Breast Malignancy** Date: ____/____/____

Results of initial SCREENING mammogram, if applicable: **Date ____/____/____**

❍Screening Mammogram was NOT PERFORMED
❍BI-RADS 0 - Assessment incomplete
❍BI-RADS 1, 2, and 3 with a suspicious clinical breast exam
❍BI-RADS 4 - Suspicious abnormality
❍BI-RADS 5 - Highly suspicious

Diagnostic Workup:

❍Surgical Consultation Date: ____/____/____
Physician: _____

❍Breast Ultrasound Date: ____/____/____

❍Diagnostic Mammogram Date: ____/____/____

- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍Repeat Breast Exam Date: ____/____/____
❍Breast Biopsy type: _____ Date: ____/____/____
❍Breast MRI *for suspected Inflammatory Breast Cancer* Date: ____/____/____
❍Consultation/2nd opinion Date: ____/____/____
❍FNA OR ❍U/S-Guided Needle Aspiration Date: ____/____/____
❍Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Refer to EWM Coverage of Diagnostic Services for more information at www.dhhs.ne.gov/ewmforms

★ Final Diagnosis:
This section must be completed before sending to EWM

Check one:

❍Cancer **not** diagnosed - no treatment necessary
❍**Cancer diagnosed** - *Please complete Breast Cancer Treatment section on Page 4*
❍Ductal carcinoma in situ ❍Lobular carcinoma in situ ❍Other carcinoma in situ ❍Invasive cancer
Date of final diagnosis or pathology report: ____/____/____

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Breast Follow-Up & Treatment Plan

Client Information:	First	MI	Last	DOB

Breast Cancer Referral & Treatment

Referral:	Client referred to _____ who will take over care. Clinician/Clinic name and city/phone
Consultation:	Consultation Date to give client options: _____
Treatment:	Treatment regimen consists of _____ (lumpectomy, surgery, chemo, radiation, etc.) Treatment Scheduled Date: _____ Treatment Performed Date: _____
Refusal:	Cancer treatment refused date _____ Client made informed decision: ❍Yes ❍No Reason for refusal: _____

Screening MRI Preauthorization Request

EWM reimburses for screening MRI as an adjunct to screening mammogram and CBE for the clients that meet the following criteria, starting at age 25:
Check one of more that apply to the client, and **provide appropriate clinical documentation**. Fax to: 402-471-0913

Requesting provider information:
Clinic Name _____
Phone #: _____
Fax #: _____

- ❍ Previous personal history of breast cancer
- ❍ Lifetime risk of 20-25% or greater based on family history using breast cancer tool for women 35+:
  www.cancer.gov/bcrisktool/ (for women under 35, go to https://ibis.ikonopedia.com/)
- ❍ Client has ❍BRCA1 ❍BRCA2 ❍Other mutation_____ Date of genetic testing: ____/____/____
- ❍ First-degree relative with BRCA1 or BRCA2 (parent, brother, sister, child) Relative: _____ Date of genetic testing: ____/____/____
- ❍ Previous Radiation Therapy to chest, between the ages of 10-30 Age: _____ Purpose of radiation: _____
- ❍ Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first-degree relatives with one of these syndromes

EWM staff use only. Request approved: ❍Yes ❍No Program signature: _____ Date: ____/____/____ Authorization **expires** one month after date of **signature**

6 Month Follow-Up of Previous Abnormal Finding

Past Results: why does client need follow-up?

Last Clinical Breast Exam Result/Finding: ❍Negative/Benign ❍Suspicious for breast malignancy Date: ____/____/____
Last Screening or Diagnostic Mammogram Result: _____ Date: ____/____/____
Last Breast Ultrasound Result: _____ Date: ____/____/____
Last Treatment: _____ Date: ____/____/____

6 Month Follow Up: Only for clients 40-74. What are the client's **current** results? Please note follow-up is not reimbursable for clients under 40.

Current Results:

Client reports symptoms: ❍NO ❍YES, list symptoms: _____
DATE: ____/____/____ Clinical Breast Exam Results (check one): ❍Negative/Benign ❍Suspicious for breast malignancy
DATE: ____/____/____ Mammogram Results (check one): ❍Negative ❍Benign ❍Probably Benign
DATE: ____/____/____ Breast Ultrasound Results (check one): ❍Negative ❍Benign ❍Probably Benign

If any other results must do new workup on Page 3

DATE: ____/____/____ Consultation by _____ Clinic Name: _____
DATE: ____/____/____ Biopsy: Type: _____ Results: _____ ** Must do new workup on page 3*

Name of Clinic:	City:	Date: