CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

Every Woman Matters

4/2022

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

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 DOB on pages 3 and 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 pg 73 and pg 80 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 ⇢ ⇢ ⇢

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

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 cervical 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 cervical 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

Cervical Follow-Up and Treatment Plan

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

Client Information:	**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 this form to EWM along with Pap test and colposcopy results when diagnostic workup is complete. Must follow current ASCCP guidelines: www.ASCCP.org

Pap/HPV results: Find the client's result below and mark the date of service for the Pap/HPV and procedure listed directly underneath.
If your client's procedure is NOT listed directly underneath the Pap/HPV result, it may not be reimbursable by EWM. Call EWM to discuss.

Co-Testing	HPV	Unsatisfactory	HPV- AS-CUS / LSIL	HPV 16/18 AS-CUS / LSIL	HPV- ASC-H / HSIL	HPV 16/18 ASC-H / HSIL	AGC Any HPV result	Sq. Cell Carcinoma
Date___/___/___ ❍Negative Pap	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___
❍Cervical lesion ❍Colposcopy with biopsy DOS:____/____/____ **HPV+ Age 30-39** ❍Repeat co-testing in 1 year (must re-enroll in State Pap Program if under 40) **Age 40+** ❍If HPV 16 or 18 Colposcopy with biopsy DOS:____/____/____	**HPV+ Age 30-39** ❍Repeat HPV testing in 1 year (must re-enroll in State Pap Program if under 40) **Age 40+** ❍If HPV 16 or 18 Colposcopy with biopsy DOS:____/____/____	❍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 HPV test allowed per guidelines)* **Ages 30+** ❍Colposcopy with biopsy DOS: ____/____/____	**Ages 25-29** ❍Repeat HPV at 1 year **Ages 30-65** ❍Repeat co-testing at 1 year	❍Colposcopy w/ Biopsy (biopsy results <CIN2 5-year CIN 3 risk is 2.9% 1-year follow-up) DOS: ___/___/___ ❍Repeat HPV at 1 year interval ❍Repeat HPV at 3 year interval	❍Immediate diagnostic LEEP for Pap and colpo result discrepancy DOS: ___/___/___ ❍Repeat colposcopy in 1 year	❍Expedited Treatment or Colposcopy with biopsy Acceptable (25-59% CIN3 risk) DOS: ___/___/___ ❍Colposcopy with biopsy recommended (4-24% CIN 3 risk) ❍Immediate diagnostic LEEP for Pap and colpo discrepancy DOS: ___/___/___ ❍Repeat HPV test 6 months	**All Subcategories:** ❍Colposcopy with biopsy + ECC and ❍Endometrial biopsy* ❍Both to be done on the same day DOS: ___/___/___ **Atypical Endometrial Cells:** ❍Endometrial and endocervical sampling DOS: ___/___/___ **If no endometrial pathology:** ❍Colposcopy DOS: ___/___/___	❍Treatment referral to OB/GYN *Complete page 4: Cervical Cancer Treatment Section*
❍Consultation or second opinion:		Physician:		Clinic Name:			Date of Service: ____/____/____	
❍Client Refused *Initiate: Client Informed Refusal Form/Service Provider Document*								

DOS = Date of Service

★ **Final Diagnosis:** This section must be completed before sending to EWM	**Check one:**
	❍Normal/Benign Inflammation; HPV/Condylomata/Atypia; Treatment not indicated / Repeat Pap/HPV or Co-test 1 year ❍Inconclusive Results ❍CIN I ❍CIN II ❍CIN III carcinoma in situ ❍Invasive Cancer **For CIN II and greater, complete page 4: Cervical Cancer Referral and Treatment** Date of final diagnosis or pathology report: _____/_____/_____

Cervical Follow-Up and Treatment Plan

Women under age 40 who require Pap at 1 year as follow-up must enroll in the ***Nebraska State Pap Plus Program*** in order for this service to be covered. **CIN II or III with no margins involved:** Repeat co-testing at 12 & 24 months.

Client Information:	**First**	**MI**	**Last**	**DOB**

Cervical 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: _____ 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 Scheduled Date: _____ Treatment Performed Date: _____
Refusal:	Cancer treatment refused date _____ Client made informed decision: ❍Yes ❍No Reason for refusal: _____

Age 21-39

Follow Up not covered by Every Woman Matters
Women under 40 who are in need of 12-24 month repeat Pap/HPV must enroll in the
Nebraska State Pap Plus Program in order to have the Pap test covered

6 Month Follow-Up of Previous Abnormal Finding

Age 40-74	**Age 40-74**	
Prior History*: Prior Pap test date: ____/____/____ Results: _____		
CIN II or III with No Treatment Done Observation - colposcopy and cytology at 6 month intervals for 12 months Date: ____/____/____ Results: _____	**CIN II or III with margins involved** Colposcopy and cytology with ECC Re-evaluated at 4-6 months Date: ____/____/____ Results: _____	
Name of Clinic:	City:	Date: ____/____/____

Fax: 402-471-0913 || Mail: Every Woman Matters, P.O. Box 94817, Lincoln, NE 68509-4817 || Questions: 800-532-2227
To view instructions or to print out forms: www.dhhs.ne.gov/EWMforms

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.