SPIPA Native Women's Wellness Program Screening Services

Last Name	First	MI	DOB		SSN
Address	**City**		**State**	**Zip**	**Phone**

Insurance Coverage:
☐ Medicaid/Medicare Part B ☐ Other Insurance _____ **(please specify)**

☐ Underinsured
☐ **None (NWWP to pay)**

☐ If no insurance, was patient referred to Health Market Place/ Medicaid?

Race: Hispanic/Latin origin? ☐ **Yes** ☐ **No** (please check one)

Ethnicity (select all that apply)**:**
☐ American Indian /Alaska Native/ First Nations
☐ Pacific Islander/Hawaiian
☐ White/Caucasian
☐ African American/Black
☐ Asian
☐ Other

Income Eligible?
☐ Yes ☐ No (If you are below the maximum income on the NWWP "Income Eligibility Table", check yes. If you are above it, check no)

Tobacco User ☐ Yes ☐ No ☐ rather not say
Referred to cessation ☐ Yes ☐ No
Provided resources for quit ☐ Yes ☐ No ☐ Refused

****** FOR OFFICE USE ONLY ****** ****** FOR OFFICE USE ONLY ****** ****** FOR OFFICE USE ONLY ******

Provider Location:	Chart#	Date: ___/___/_____

Cervical Screening

Cervical History ***High risk for cervical cancer?*** ☐ Yes ☐ No ☐ Unknown

Prior PAP test? ☐ Yes ☐ No ☐ Unknown **Date of prior PAP:** _____/_____/_____

HPV vaccine? ☐ Yes ☐ No ☐ Unknown **# Received** _____ **Age started** _____ **Age completed** _____

History of ovarian cancer? ☐ Yes ☐ No ***Family history?*** ☐ Yes ☐ No ☐ Unknown

Pelvic Exam ☐ **Completed** ☐ **Refused** ☐ **Not Done/Normal pelvic exam within past 12 months** ☐ **Hysterectomy**

Results

☐ Normal
☐ Abnormal – Suspicious for cancer
☐ Abnormal – Not suspicious for cancer

Recommendations

☐ Pelvic ultrasound
☐ Gynecological consultation
☐ Follow PAP recommendations (below)

HPV Test ☐ **Co-Test/Screen** ☐ **Reflex** ☐ **Not Done**

Results

☐ HPV+ (No genotyping/UNK)
☐ HPV+ (Genotyping 16 or 18)
☐ HPV-
☐ Unknown

Date Result Received: _____/_____/_____

Date Patient Notified: _____/_____/_____

PAP Test ***Specimen Adequacy:*** ☐ **Satisfactory** ☐ **Unsatisfactory**

Results

☐ Negative
☐ ASC-H
☐ ASC-US
☐ Low Grade SIL/HPV
☐ High Grade SIL
☐ Squamous Cell Carcinoma
☐ AGC
☐ Endometrial Cells
☐ AIS (Adenocarcinoma in situ)
☐ Adenocarcinoma

Date Result Received: _____/_____/_____

Date Referral Made: _____/_____/_____

Date Patient Notified: _____/_____/_____

Recommendations:

PAP in:
☐ 1 year ☐ 2 years ☐ 3 years ☐ 5 years
☐ Short term follow-up in _____ months
☐ Repeat PAP immediately
☐ Colposcopy **without** biopsy
☐ Colposcopy with ECC
☐ Colposcopy **with** biopsy
☐ Other biopsy
☐ Gynecologic consultation
☐ CKC (Cold Knife Cone)
☐ ECC (Endocervical Curettage)
☐ Hysterectomy
☐ LEEP

Workup status:
☐ Diagnostic work-up planned
☐ DX work-up not planned

Case Management

Date of initial call ___/___/___ Date of second call ___/___/___

Date of initial letter ___/___/___ Date of certified letter ___/___/___

☐ **Patient lost to follow up**

Provider Notes

Provider Signature:

Date:

Breast Screening

Breast History | ***High risk for breast cancer?*** ☐ Yes ☐ No ☐ Unknown

History of breast cancer? ☐ Yes ☐ No ***Family history?*** ☐ Yes ☐ No ☐ Unknown

Does patient have breast symptoms today? ☐ Yes ☐ No

Prior mammogram? ☐ Yes ☐ No ☐ Unknown **Date of prior mammogram:** _____/_____/_____

Clinical Breast Exam (CBE) ☐ **Completed** ☐ **Refused** ☐ **Not Indicated**

Results

- ☐ Normal exam
- ☐ Benign findings
- ☐ Discrete palpable mass – suspicious for cancer
- ☐ Discrete palpable mass – NOT suspicious for cancer
- ☐ Bloody/serous nipple discharge
- ☐ Nipple with areolar scaliness
- ☐ Skin dimpling or retraction

Recommendations

- ☐ Follow routine screening
- ☐ diagnostic referral
- ☐ Other:

Initial Mammogram ☐ **Screening** ☐ **Diagnostic**

Results

- ☐ Negative
- ☐ Benign findings
- ☐ Probably benign
- ☐ Suspicious (consider biopsy)
- ☐ Highly suggestive of malignancy
- ☐ Known malignancy
- ☐ Incomplete, need additional imaging evaluation
- ☐ Results pending

Date Result Received: _____/_____/_____

Date Referral Made: _____/_____/_____

Date Patient Notified: _____/_____/_____

Recommendations

- ☐ Follow routine screening
- ☐ Short-term follow-up mammogram in _____ months
- ☐ Assessment incomplete, need additional imaging
- ☐ Additional mammographic views
- ☐ Film comparison required
- ☐ Ultrasound
- ☐ Fine Needle Aspiration (FNA)
- ☐ Biopsy
- ☐ Surgical consult
- ☐ CBE by consult

Workup status

- ☐ Diagnostic work-up planned
- ☐ DX work-up not planned

Screening MRI ☐ **Indicated (Patient is HIGH RISK)** ☐ **Not Indicated (Patient is NOT high risk)**

Date of Prior Authorization: _____/_____/_____

** All program sponsored screening MRIs must have prior authorization from SPIPA's Native Women's Wellness Program Coordinator **

Please complete Breast Diagnostic Form for all MRIs

Date Referral Made: _____/_____/_____

Date MRI Complete: _____/_____/_____

Date Result Received: _____/_____/_____

Date Patient Notified: _____/_____/_____

Case Management

Date of initial call ___/___/___ Date of second call ___/___/___

Date of initial letter ___/___/___ Date of certified letter ___/___/___

☐ **Patient lost to follow up**

Provider Notes

Provider Signature:

Date:

****PLEASE RETURN COMPLETED FORM TO SPIPA NWWP STAFF ****

SPIPA USE ONLY:

- ☐ Pending additional screening information
- ☐ Pending diagnostic information
- ☐ Cycle complete