MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)

CERVICAL DIAGNOSIS AND TREATMENT

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS)

REFERRING PROVIDER (FOR DIRECT BILLING)

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)

DATE OF BIRTH ____/____/____ MM DD YYYY

SOCIAL SECURITY NUMBER ____ – ____ – ____

CLIENT ELIGIBILITY VERIFIED ☐ Yes ☐ No

INSURANCE COVERAGE ☐ Yes ☐ No

DEDUCTIBLE MET ☐ Yes ☐ No

REFERRAL FEE ☐

TYPE OF MEDICARE ☐ Part A ☐ Part A and B

BCCT ☐ Yes ☐ No

B. CERVICAL DIAGNOSTIC PROCEDURES

Specialist Consultation ____/____/____ MM DD YYYY ☐ Reporting Only

Diagnostic Work-up Planned ☐ None ☐ 0-60 Days ☐ 61-90 days

☐ **Colposcopy without Biopsy** ____/____/____ MM DD YYYY ☐ Reporting Only

☐ **Colposcopy** ____/____/____ MM DD YYYY ☐ Reporting Only

☐ **Polypectomy** ____/____/____ MM DD YYYY ☐ Reporting Only

☐ **Cervical Biopsy**
☐ **Endocervical Biopsy/ECC Biopsy**
☐ **Endometrial Biopsy (Can only be reimbursed with cervical biopsy)**

☐ 1 Additional Cervical Biopsy
☐ 2 Additional Cervical Biopsies
☐ 3 Additional Cervical Biopsies

☐ Colposcopy inadequate, need further diagnostic

Diagnostic procedures, choose ONLY one ____/____/____ MM DD YYYY ☐ Reporting Only

☐ **LEEP** ←— **OR** —→ ☐ **Cold Knife** ←— **OR** —→ ☐ **Endocervical Curettage (alone)**

☐ (1) Biopsy
☐ (2) 1 Additional Biopsy
☐ (3) 2 Additional Biopsies
☐ (4) 3 Additional Biopsies

Other Cervical Procedure (Specify)________________________________ ____/____/____ MM DD YYYY
(Use only for procedures performed for management of a cervical lesion.)

Next Cervical Cancer Screening Date ____/____ MM YYYY

Status of Final Diagnosis

☐ (1) Work-up Complete (Complete Section C)
☐ (2) Work-up Pending
☐ (3) Lost to F/U (Describe in comment section)
☐ (4) Work-up Refused (Describe in comment section/Must have signed waiver)
☐ (5) Irreconcilable (Does not follow typical protocol - **FOR OFFICE USE ONLY**) Date: ______ / ______ / ______

C. CERVICAL DIAGNOSIS

Final Diagnosis (RECORD MOST SEVERE RESULT) ***(Diagnostic results with (*) require treatment)***

- ☐ (1) Normal/Benign Reactive/Inflammation
- ☐ (2) HPV/Condylomata/Atypia
- ☐ (3) CIN I/Mild Dysplasia/Low grade SIL (Biopsy Diagnosed)*
- ☐ (4) **CIN II/Moderate Dysplasia (Biopsy Diagnosed)*** (Refer to BCCT)
- ☐ (5) **CIN III/Severe Dysplasia/High Grade SIL/Carcinoma In Situ (CIS), Stage 0 (Biopsy Diagnosed)*** (Refer to BCCT)
- ☐ (6) **Invasive (Biopsy Diagnosed)*** (Refer to BCCT)
- ☐ (7) Other___________________________________
  (Use if woman has no cervix for cancer types: Vulval, Vaginal, Endometrial, Uterine, Ovarian)

Final Diagnosis Date _______/_______/_________
MM DD YYYY

D. CERVICAL TREATMENT

Status of Treatment
- ☐ Started
- ☐ Pending
- ☐ Lost to F/U (Describe in comment section)
- ☐ Work up refused (Describe in comment section/Must have signed waiver)
- ☐ Not Needed

Type
- ☐ Cryotherapy
- ☐ Conization (LEEP, Cold Knife)
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Surgery
- ☐ Immunotherapy
- ☐ Other Cancer Therapy - Specify ____

Treatment Facility
Facility Name/City

Date Treatment Started __________ / __________ / ___________
MM DD YYYY

Comments