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

SCREENING REPORT

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

ENROLLMENT SITE/SATELLITE SITE (NAME AND ADDRESS)	REFERRING PROVIDER (FOR DIRECT BILLING)

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER
	___-___-___

DATE OF BIRTH	CLIENT ELIGIBILITY VERIFIED	INSURANCE COVERAGE	DEDUCTIBLE MET	REFERRAL FEE	MEDICARE
___/___/___ MM DD YYYY	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐ Part A ☐ Part A and B

VISIT TYPE ☐ Initial ☐ Annual ☐ Rescreen
☐ Initial CBE only ☐ Annual CBE only ☐ Mammogram only

Height	Weight	BMI	Blood Pressure
ft. in.	lbs.		1st Reading ___/___ 2nd Reading ___/___ Average ___/___

B. BREAST CANCER SCREENING

☐ Reporting Only

B 1. Does client report any BSE symptoms? ☐ Yes ☐ No *(If "YES" complete B2.)* **Date of CBE** ___/___/___ (MM/DD/YYYY)

B 2. Symptoms Reported By Client *(Check any that apply. If 1, 2, 3 or 4B is checked, may have two (2) diagnostics at clinician's discretion.)*

☐ (1) Lump
☐ (2) Nipple discharge
☐ (3) Skin changes *(dimpling, retraction, new nipple inversion, ulceration, Paget's disease)*
☐ (4A) Pain/Tenderness - 1st occurrence ☐ (4B) Pain/Tenderness - 2nd occurrence
☐ (5) Other (specify) _____

B 3. CBE within normal limits and findings Present at CBE *(check yes or no and one explanation)*

☐ **Yes** ☐ Within normal limits
☐ (1) Benign finding *(fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)*

☐ **No - Suspicious for cancer** *(Any checked findings requires completion of two (2) diagnostic procedures entered on purple breast form.)*

☐ (2) Discrete palpable mass *(includes masses that may be diffuse, poorly defined thickening, cystic or solid)*
☐ (3) Nipple discharge
☐ (4) Nipple or areolar scaliness or erythema
☐ (5) Skin dimpling retraction; new nipple inversion; peau d'orange; ulceration; one breast lower than usual; prominent veins, unilateral; unusual increase in size, unilateral
☐ (6) Enlarged, tender, fixed or hard palpable supraclavicular, infraclavicular or axillary lymph nodes; also swelling of upper arm
☐ Focal pain and tenderness

B 4. High Risk for Breast Cancer ☐ (1) Yes ☐ (2) No ☐ (9) Not assessed/Unknown

Rescreen CBE Planned ☐ Yes ☐ No ___/___ MM YYYY
(must be less than 10 months)

Diagnostic Work-up Planned ☐ Yes ☐ No ___/___/___ MM DD YYYY
(must be less than 60 days)

B 5. Mammogram Results ☐ Reporting Only

☐ (4) Mammogram not done or CBE done and diagnostic workup planned
☐ (1) Routine screening mammogram
☐ (2) Mammogram performed to evaluate symptoms:
☐ Personal history of breast cancer
☐ Previous abnormal mammogram results (rescreen)
☐ (5) Cervical record only, no breast service provided
☐ (6) Referred to direct biller
☐ (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)
Date client referred for diagnosis. ___/___/___ MM DD YYYY

Mammography provider facility *(facility name/city)* ☐ Mammogram Van

Previous mammogram ☐ Yes ☐ No ☐ Unknown **Date of last mammogram** ___/___ MM YYYY **Date of this mammogram** ___/___/___ MM DD YYYY

Type of mammogram ☐ Screening ☐ Diagnostic ☐ Tomosynthesis **Method used for mammogram** ☐ Digital ☐ Conventional

SMHW mammogram result *(check one)* *(results with * require additional follow-up)*

	Left	Right	
Normal	☐	☐	(1) Negative *(Category 1)*
	☐	☐	(2) Benign Finding *(Category 2)*
Abnormal	☐	☐	(3) Probably Benign *(Category 3)*
	☐	☐	(4) **Suspicious Abnormality** *(Category 4)**
	☐	☐	(5) **Highly Suggestive of Malignancy** *(Category 5)**
	☐	☐	(7) Unsatisfactory-not interpreted, repeat *(Not Paid)*
	☐	☐	(14) Need evaluation or film comparison (*Category 0*)

(Indicate why only one breast had mammogram in COMMENTS)

Further diagnostic planned for: (3) Probably Benign: ☐ Yes ☐ No

Rescreen mammogram planned ☐ Yes ☐ No
(must be less than 10 months) ___/___ MM YYYY

Diagnostic work-up planned ☐ Yes ☐ No
(must be less than 60 days) ___/___/___ MM DD YYYY

Referred for diagnostic testing/direct bill *(physician/facility name)*

☐ MRI (High Risk ONLY. Prior authorization required.) Report L/R results in Section D. Comments. ___/___/___ MM DD YYYY

C. CERVICAL CANCER SCREENING (Indications for Pap Test)

☐ (6) Breast and Pelvic exam only (No Cervical Service)

☐ (1) Routine Pap test (*screening*)
☐ (2) Patient under surveillance for previous abnormal (*rescreen*)
☐ (5) Pap test not done. Patient proceeded directly for diagnostic work-up or HPV testing
☐ (4) Pap after primary HPV positive (+)
☐ (3) Non-program Pap referred in for diagnostic evaluation
☐ (9) Unknown

_____/_____/_____
MM DD YYYY

High Risk for Cervical Cancer
☐ (1) Yes
☐ (2) No
☐ (9) Not assessed/ unknown

C 1. Pelvic Exam Results

Pelvic Exam WNL? ☐ Yes ☐ No
(Additional information required in "No" selected, See C 2.)

Hysterectomy? ☐ Yes ☐ No
☐ Cervix absent
☐ Cervix absent due to cervical cancer (*needs annual Pap test*)
☐ Cervix present
☐ Reason for hysterectomy unknown

Date of Pelvic Exam _____/_____/_____
MM DD YYYY

Reproductive Status (check one)
☐ a) Premenopausal
☐ b) Postmenopausal

C 2. Pelvic Exam Findings

☐ **Reporting Only**

Findings Present at Pelvic Exam (check only one)

☐ **1) Cervix**
☐ a) Polyp
☐ b) Leukoplakia (white lesions)
☐ c) Friable
☐ d) Ulceration
☐ e) Exophytic growth
☐ f) Ectropion
☐ g) Stenotic OS
☐ h) Cervical mass
☐ i) Other: _____

☐ **2) Exam Complicated by Obesity**

Rescreen planned ☐ Yes ☐ No _____/_____
MM YYYY

Diagnostic planned ☐ Yes ☐ No _____/_____/_____
(must be less than 90 days) MM DD YYYY

C 3. Pap Test Results

☐ **Reporting Only**

Previous Pap test ☐ Yes ☐ No ☐ Unknown

Date of last Pap test _____/_____
MM YYYY

Date of this Pap test _____/_____/_____
MM DD YYYY

Specimen adequacy
☐ Satisfactory
☐ Unsatisfactory due to _____
☐ Unknown

Specimen type
☐ Conventional Smear
☐ Liquid Based

☐ **Annual Pap due to previous treatment for cervical cancer**

Pap test result *(check one) (Results with (*) require additional follow-up)*

Normal
☐ (1) Negative for intraepithelial lesion or malignancy

Abnormal
☐ (2) Atypical Squamous Cells of Undetermined Significance (ASC-US)(May have HPV test)
☐ **(3) Lowgrade SIL** *(HPV/Mild Dysplasia/CIN I)**
☐ **(4) Atypical Squamous Cells, cannot exclude HSIL** *(ASC-H)**
☐ **(5) Highgrade SIL** *(with features suspicious for invasion/CIN II-III/CIS)**
☐ **(6) Squamous Cell Cancer***
☐ **(7) Atypical Glandular Cells*** (*including atypicalendocervical adenocarcinoma in situ and adenocarcinoma*)
☐ **(8) Adenocarcinoma in situ***
☐ **(9) Adenocarcinoma***
☐ (11) Other _____

Endocervical Cells ☐ Yes ☐ No

C 4. HPV Test Date _____/_____/_____ MM/DD/YYYY

☐ **Reporting Only**

Indication for HPV Test
☐ (1) Cotesting/Screening
☐ (2) Reflex
☐ (3) Not Done
☐ (9) Unknown

HPV Test Result
☐ (1) Positive with genotyping not done/unknown
☐ (2) Negative
☐ (4) Positive with positive genotyping
☐ (5) Positive with negative genotyping
☐ (9) Unknown

HPV DNA Genotype 16 or 18 Positive (*Only report if PAP negative and HPV High Risk Group Positive)*
☐ Yes
☐ No
☐ No Test Performed

Rescreen Pap planned ☐ Yes ☐ No _____/_____
(less than 10 months) MM YYYY

Diagnostic work-up planned ☐ Yes ☐ No _____/_____/_____
(must be less than 90 days) MM DD YYYY

Referred for diagnostic work-up/direct biller
(physician/facility name)

Date of next routine Pap screening _____/_____
MM YYYY

D. COMMENTS