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	SOCIAL SECURITY NUMBER	CLIENT ELIGIBILITY VERIFIED
____/____/____ MM DD YYYY	____ – ____ – ____	☐ Yes ☐ No

INSURANCE COVERAGE	DEDUCTIBLE MET	REFERRAL FEE	TYPE OF MEDICARE	BCCT
☐ Yes ☐ No	☐ Yes ☐ No	☐	☐ Part A ☐ Part A and B	☐ 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
☐ Immunohistochemistry (88342)
☐ Additional Immunohistochemistry (88341)

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
(Use only for procedures performed for management of a cervical lesion.)

- ☐ Dilitation and Curettage
- ☐ Biopsy of Vagina if no Cervix
- ☐ Biopsy of Vulva if no Cervix

____/____/____ MM DD YYYY

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**) ____/____/____ MM DD YYYY

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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

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