CERVICAL SPECIALIST REFERRAL FORM

WOMEN'S HEALTH CONNECTION (WHC) IN PARTNERSHIP
WITH ACCESS TO HEALTHCARE NETWORK (AHN)

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

TO BE COMPLETED BY THE PRIMARY CARE PROVIDER (PCP)		
Last Name:	First Name:	DOB (MM/DD/YY):
PCP Name:	PCP Phone [ex. (111) 111-1111]:	
CONTACT AHN AT 844-469-4930 TO SCHEDULE AN APPOINTMENT WITH A SPECIALIST		
Specialist Name:		
Appointment Date (MM/DD/YY):	Specialist phone/fax:	

PELVIC EXAM AND PAP FINDINGS		
Has the patient had a hysterectomy?	☐ Yes	☐ No
If yes, is the cervix present?	☐ Yes	☐ No
Was the hysterectomy due to CIN or invasive cervical cancer?	☐ Yes	☐ No

Cytology Results

Pap specimen type ☐ Liquid ☐ Conventional

☐ Negative for intraepithelial lesion or malignancy	☐ ASC-H
☐ ASC-US	☐ Atypical glandular cells
☐ Low Grade SIL (LSIL)	☐ High Grade SIL (HSIL)
☐ Adenocarcinoma in situ (AIS)	☐ Squamous cell carcinoma
☐ Adenocarcinoma	☐ Other

Date of Pap (MM/DD/YY):

Pelvic Exam Results

☐ Normal	☐ Not performed (explain in notes)
☐ Abnormal cervix – Suspicious for cervical cancer	☐ Abnormal cervix – Not susp. for cervical can.
☐ Not indicated or not needed	☐ Refused

Date of Pelvic Exam (MM/DD/YY):

HPV Test Results:

☐ Positive with genotyping not done/unknown	☐ Negative
☐ Positive with positive genotyping	☐ Unknown
☐ Positive with negative genotyping	

Date of HPV test(s) (MM/DD/YY):

Notes:

Primary Clinician Signature:	Date of Service (MM/DD/YY):

TO BE COMPLETED BY SPECIALIST FOR EACH OFFICE VISIT			
Repeat Pelvic Exam			
☐	Normal Exam	☐	Not suspicious for cancer
☐	Suspicious for cancer	☐	Other
Date of Service (MM/DD/YY):			
Diagnostic Procedures Recommended/Performed			
☐	Colposcopy without biopsy	☐	*CKC
☐	Colposcopy with biopsy	☐	*Endometrial biopsy
☐	Colposcopy with ECC	☐	Excision of endocervical polyp(s)
☐	*LEEP	*Prior authorization required	
Date of Service (MM/DD/YY):			
Gynecologic Consultation			
☐	Review results/discuss follow-up	☐	No intervention – routine follow-up
☐	Short term follow up in __ months	☐	Surgery or treatment recommended
Date of Service (MM/DD/YY):			
Final Diagnosis			
☐	Normal/benign reaction/inflammation	☐	LSIL
☐	HPV/Condylomata/Atypia	☐	HSIL
☐	CIN I	☐	Invasive carcinoma
☐	CIN II	☐	Other
☐	CIN III – CIS or AIS	☐	Short term follow-up in months
Date of Service (MM/DD/YY):			
Treatment Status			
☐	Treatment not needed	☐	Treatment started
☐	Treatment refused		
Date treatment started (MM/DD/YY):		Treatment Facility:	
Notes:			
Specialist Signature:		Date (MM/DD/YY):	
PLEASE FAX ALL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918 WOMEN'S HEALTH CONNECTION OFFICE USE ONLY			
Date received (MM/DD/YY):		Date entered (MM/DD/YY):	
MED-IT ID:			

This publication is supported by the Nevada State Division of Public and Behavioral Health (DPBH) through grant number 5 NU58DP007102-04-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the DPBH or CDC