WOMEN'S HEALTH CONNECTION (WHC) CERVICAL SPECIALIST REFERRAL FORM

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

TO BE COMPLETED BY THE PRIMARY PROVIDER (PCP)

Last Name:	First Name:	DOB (mm/dd/yyyy):
PCP Name:	PCP Phone:	

CONTACT AHN AT 844-469-4930 TO SCHEDULE AN APPOINTMENT WITH A SPECIALIST

Specialist Name:	Appointment date (mm/dd/yyyy):
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 Cervical Intraepithelial Neoplasia (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/yyyy):

Pelvic Exam Results

☐ Normal	☐ Not performed (explain in notes)
☐ Not indicated or not needed	☐ Refused
☐ Abnormal cervix – suspicious for cervical cancer (explain in notes)	☐ Abnormal cervix – <u>not</u> suspicious for cervical cancer (explain in notes)

Date of pelvic exam (mm/dd/yyyy):

Notes:

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PELVIC EXAM AND PAP FINDINGS (CONTINUED)

HPV Test Results

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

Date of HPV test(s) (mm/dd/yyyy):

Notes:

Primary Clinician signature:	Date (mm/dd/yyyy):

TO BE COMPLETED BY SPECIALIST FOR EACH VISIT

Repeat Pelvic Exam

- ☐ Normal
- ☐ Suspicious for cancer
- ☐ Not suspicious for cancer
- ☐ Other

Date of service (mm/dd/yyyy):

Diagnostic Procedures Recommended / Performed

- ☐ Colposcopy without biopsy
- ☐ Colposcopy with biopsy
- ☐ Colposcopy with endocervical curettage (ECC)
- ☐ Excision of endocervical polyp(s)
- ☐ Cold Knife Conization (CKC)
- ☐ Endometrial biopsy
- ☐ Loop electrosurgical excision procedure (LEEP)

Note: All procedures require prior authorization.

Date of service (mm/dd/yyyy):

Gynecology Consultation

- ☐ Review results / discuss follow-up
- ☐ Short term follow-up in months
- ☐ No intervention – routine follow-up
- ☐ Surgery or treatment recommended

Date of service (mm/dd/yyyy):

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TO BE COMPLETED BY SPECIALIST FOR EACH VISIT (CONTINUED)

Final Diagnosis (Dx)

- ☐ Normal / benign reaction / inflammation
- ☐ HPV / Condylomata / Atypia
- ☐ CIN I
- ☐ CIN II
- ☐ CIN III – CIS or AIS
- ☐ LSIL
- ☐ HSIL
- ☐ Invasive carcinoma
- ☐ Other
- ☐ Short term follow-up in months

Date of service (mm/dd/yyyy):

Treatment (Tx) Status

- ☐ Tx not needed
- ☐ Tx started
- ☐ Tx refused

Date Tx started (mm/dd/yyyy):	Tx facility:

Notes:

Specialist signature:	Date (mm/dd/yyyy):

PLEASE FAX ALL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918

WHC OFFICE USE ONLY

Date received (mm/dd/yyyy):	Date entered (mm/dd/yyyy):	Med-IT ID#:

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