Washington State Department of Health

Washington Breast & Cervical Health Program — Take Charge of Your Health!

WASHINGTON BREAST AND CERVICAL HEALTH PROGRAM
WOMEN'S HEALTH EXAMINATION AND REIMBURSEMENT FORM

Please Print Clearly

ALL SECTIONS ON THIS FORM TO BE COMPLETED BY CLINIC STAFF

CLIENT NAME (Last, First, MI)	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	DATE OF EXAM (mm/dd/yyyy)

CLINICAL SCREENING SITE	PROVIDER NAME	CHART NUMBER

PRIMARY INSURANCE (IF THERE IS A PRIMARY INSURANCE COVERAGE, PLEASE SUBMIT EOB TO WBCHP FOR ADDITIONAL REIMBURSEMENT UP TO PROGRAM FEE SCHEDULE AMOUNT)

Name of insurance company ______________________ Policy/Identification number ______________

HEALTH HISTORY

CERVICAL HEALTH HISTORY: Have you ever had a Pap test? ☐Yes ☐No ☐Unknown

If yes, was your last Pap test more than 5 years ago? ☐Yes ☐No

Date of last Pap test (mm/dd/yyyy) ______________ **Results** ☐ Normal ☐ Abnormal

LMP (Date) ____________

Have you had a hysterectomy? ☐ Yes ☐ No **If Yes, was it for cervical cancer?** ☐ Yes ☐ No ☐ Don't Know

Identified Risk Factors for Cervical Cancer:

Age at first intercourse less than 16 ☐ Yes ☐ No **Abnormal Pap history** ☐ Yes ☐ No

More than 5 sexual partners (lifetime) ☐ Yes ☐ No **Current smoker** ☐ Yes ☐ No

History of HPV? ☐ Yes ☐ No **History of HIV?** ☐ Yes ☐ No **Referred to Tobacco Quit Line** ☐ Yes ☐ No

BREAST HEALTH HISTORY: Have you had a screening mammogram BEFORE enrollment in WBCHP? ☐Yes ☐No ☐Unknown

If yes, Date of screening mammogram (mm/dd/yyyy) ________ **Results** ☐ Normal ☐ Abnormal

Identified Risk Factors for Breast Cancer:

Has your mother, sister, or daughter ever had breast cancer? ☐ Yes ☐ No **Have you ever had breast cancer?** ☐ Yes ☐ No

Do you have any pre-malignant biopsy history? ☐ Yes ☐ No **Never given birth or first birth after age 30** ☐ Yes ☐ No

OTHER HEALTH INFORMATION BMI ____________

Do you have a disability? ☐ Yes ☐ No **If Yes, does this disability make accessing WBCHP services difficult?** ☐ Yes ☐ No

Type of disability ☐ Mobility / physical ☐ Hearing ☐ Visual ☐ Developmental ☐ Other (specify) ______________

Do you identify as? ☐ Heterosexual ☐ Lesbian ☐ Bi-Sexual ☐ Transgender **Do you have sexual contact with?** ☐ Men ☐ Women ☐ Both

BREAST: Client Reports Breast Symptoms ☐ Yes ☐ No **If Yes, specify** ______________________

CBE Performed ☐ Yes ☐ No **If No, Why** ☐ Not Indicated / Not Needed ☐ Other / Unknown ☐ Refused

CBE Results

Normal/Benign
- ☐ Normal Exam
- ☐ Benign Finding (specify) ______________
- ☐ Implants
- ☐ Absent Breast(s)

Suspicious for Breast Cancer (*Diagnostic work-up required)
- ☐ *Discrete Palpable Mass – Suspicious for Cancer
- ☐ *Bloody or serous spontaneous nipple discharge
- ☐ *Nipple or areolar scaliness
- ☐ *Skin changes (dimpling, retraction, redness, swelling, heat)

Indication for Initial BCHP Mammogram: ☐Routine ☐ Symptoms or CBE Findings ☐ Previous abnormal mammogram ☐Other / Unknown

Initial Mammogram **not** done: ☐ Proceeded to diagnostic work-up or other imaging ☐ Recent Mammogram ☐ Not Indicated/Not Needed ☐ Refused

Refer for Mammogram ☐ Yes, Referred to ______________________

***Diagnostic Work-up Plan** ☐ Biopsy ☐ Cyst Aspiration ☐ Diagnostic Mammogram ☐ Fine Needle Aspiration ☐ Surgical Consultation / Repeat Breast Exam ☐ Ultrasound

***A mammogram (or additional mammographic views) is not sufficient evaluation of an abnormal CBE.**
Palpable breast masses need to be evaluated clinically and/or with additional imaging regardless of mammogram result.

CERVICAL: Pelvic Exam Performed ☐ Yes ☐ No, **Why?** ☐ Not Indicated/Not Needed ☐ Other / Unknown ☐ Refused

Pelvic Exam Results:

Normal/Negative
- ☐ Normal
- ☐ Absent Cervix

Suspicious for Cervical Cancer (*Diagnostic work-up required)
- ☐ *Visible Mass
- ☐ *Suspicious lesions (white patch, wart)

Other Finding
- ☐ Inflammation
- ☐ Infection
- ☐ Unusual Discharge
- ☐ Polyp

Indication for Pap Test: ☐Routine ☐Previous abnormal test ☐Diagnostic work-up or HPV only ☐ Other / Unknown ☐ Hysterectomy ☐ Pap test w/in last _____ months ☐ Not Indicated/Not Needed ☐ Refused

Pap Test Performed ☐Conventional ☐ Liquid Lab Name ______________________

Specimen Adequacy ☐ Unknown ☐ Satisfactory ☐ Unsatisfactory (If Unsatisfactory, DO NOT MARK RESULT BELOW)

Pap Test Results
- ☐ Negative
- ☐ ASC-US (HPV testing recommended)
- ☐ Low grade SIL (including HPV changes)
- ☐ *ASC-H (Atypical squamous cells cannot exclude HSIL)
- ☐ *High grade SIL (with features suspicious for invasion)
- ☐ *Squamous cell cancer
- ☐ *AGC (incl atypical, endocervical adenocarcinoma in situ and adenocarcinoma)

HPV Test Performed ☐ Yes ☐ No **If Yes, Date:** ____________ **Result is** ☐ Positive ☐ Negative ☐ Indeterminant

***Diagnostic Work-up Plan**: ☐ Biopsy ☐ Consultation ☐ Colposcopy ☐ Colposcopy with Biopsy ☐ LEEP ☐ Conization

Client Counseled/Taught About	Recommendations
☐ Risk of cervical neoplasia and/or breast cancer	☐ Next Pap test due in _____ months
☐ Importance of screening exams (breast and cervical)	☐ Next mammography/radiology due in _____ months

SERVICES BILLED

New WBCHP Client
- ☐ **99201** – Office brief new
- ☐ **99202** – Office expand new
- ☐ **99203** – Office detail new
- ☐ **99386** – Prev new age 40-64
- ☐ **99387** – Prev new age 65+

Established WBCHP Client
- ☐ **99211** – Office brief est
- ☐ **99212** – Office expand est
- ☐ **99213** – Office detail est
- ☐ **99396** – Prev est age 40-66
- ☐ **99397** – Prev est age 65+

Remember to check off type of Pap and if HPV was done in the cervical section above.

PROVIDER SIGNATURE ______________________ Date ______________

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