CERVICAL SPECIALIST REFERRAL FORM FY25

Women's Health Connection (WHC) in Partnership with Access to Healthcare Network

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Last name:	First name:	Date of birth (MM/DD/YY):

Primary care provider:	Phone [ex. (111) 111-1111]:

CONTACT WHC CARE COORDINATOR AT 844-469-4930 TO SCHEDULE AN APPOINTMENT WITH THE 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

Pelvic exam results

- ☐ Normal
- ☐ Not performed (explain in notes)
- ☐ Abnormal cervix - Suspicious for cervical cancer
- ☐ Abnormal cervix - Not suspicious for cervical cancer
- ☐ Not indicated or not needed
- ☐ Refused

HPV test result:

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

Cytology results

Pap specimen type: ☐ Liquid ☐ Conventional

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

Date of Pap (MM/DD/YY):

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

Date of pelvic exam (MM/DD/YY):

Notes:

Primary Clinician Signature:	Date (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):

☐ Gynecologic consultation

- ☐ Review results/discuss f/up
- ☐ No Intervention-Routine f/up
- ☐ Short term f/up in months
- ☐ Surgery or TX recommended

Date of Service (MM/DD/YY):

Diagnostic procedures recommended/performed

- ☐ Colposcopy without biopsy
- ☐ Colposcopy with biopsy
- ☐ Colposcopy with ECC
- ☐ *LEEP
- ☐ *CKC
- ☐ *Endometrial biopsy
- ☐ Excision of endocervical polyp(s)

*Prior authorization required

Date of Service (MM/DD/YY):

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Final diagnosis

- ☐ Normal/benign reaction/inflammation
- ☐ HPV/Condylomata/Atypia
- ☐ CIN I
- ☐ CIN II
- ☐ CIN III / carcinoma-in-situ (CIS) or adenocarcinoma in situ (AIS)
- ☐ Low Grade SIL (LSIL)
- ☐ High Grade SIL (HSIL)
- ☐ Invasive carcinoma
- ☐ Other

☐ Short term f/up in ______ months

Date of Service (MM/DD/YY):

Treatment status

- ☐ Treatment not needed
- ☐ Treatment refused
- ☐ Treatment started

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):

CaST ID#:

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