

**Wisconsin Well Woman Program
Cervical Cancer Diagnostic and Follow-Up Report (DRF)**

Instructions

Before completing this form, refer to the Cervical Cancer Diagnostic and Follow-Up Report (DRF) Instructions, F 44729I. For reimbursement, send claim plus this completed form to Wisconsin Well Woman Program (WWWP), PO Box 6645, Madison, WI 53716-0645.

Section I: Billing provider information

1. Provider ID: _____
2. Name – billing provider: _____
3. Taxonomy code: _____
4. Practice location ZIP+4: _____

Section II: Client personal information

5. Last name – client: _____
6. First name – client: _____
7. Middle initial – client: _____
8. Previous last name – client: _____
9. Client ID number: _____
10. Date of Birth – client (MM/DD/CCYY): _____

Section III: Cervical diagnostic procedures

Endocervical curettage

11. Date performed (MM/DD/CCYY): _____
12. Name – rendering provider (print): _____
13. Result (check one box only)

☐ Negative (WNL) ☐ Other non-malignant abnormality (HPV, condylomata) ☐ CIN 1, mild dysplasia* ☐ CIN 2, moderate dysplasia*	☐ CIN 3, severe dysplasia* ☐ Invasive squamous cell carcinoma* ☐ Adenocarcinoma* ☐ LSIL* ☐ HSIL*
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* indicates additional follow-up required for WWWP

Colposcopy without biopsy

14. Date performed (MM/DD/CCYY): _____
15. Name – rendering provider (print): _____
16. Result (check one box only)

☐ Negative (WNL) ☐ Other abnormality	☐ Inflammation, infection, or HPV changes* ☐ Unsatisfactory*
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* indicates additional follow-up required for WWWP

Loop electrosurgical excision procedure

17. Date performed (MM/DD/CCYY): _____

18. Name – rendering provider (print): _____

19. Result (check one box only)

☐ Negative (WNL)☐ Other non-malignant abnormality (HPV, condylomata)☐ CIN 1, mild dysplasia*☐ CIN 2, moderate dysplasia*☐ CIN 3, severe dysplasia*☐ Invasive squamous cell carcinoma*☐ Adenocarcinoma*☐ LSIL*☐ HSIL*

* indicates additional follow-up required for WWWP

Colposcopy with biopsy

20. Date performed (MM/DD/CCYY): _____

21. Name – rendering provider (print): _____

22. Result (check one box only)

☐ Negative (WNL)☐ Other non-malignant abnormality (HPV, condylomata)☐ CIN 1, mild dysplasia*☐ CIN 2, moderate dysplasia*☐ CIN 3, severe dysplasia*☐ Invasive squamous cell carcinoma*☐ Adenocarcinoma*☐ LSIL*☐ HSIL*

* indicates additional follow-up required for WWWP

Cold knife cone

23. Date performed (MM/DD/CCYY): _____

24. Name – rendering provider (print): _____

25. Result (check one box only):

☐ Negative (WNL)☐ Other non-malignant abnormality (HPV, condylomata)☐ CIN 1, mild dysplasia*☐ CIN 2, moderate dysplasia*☐ CIN 3, severe dysplasia*☐ Invasive squamous cell carcinoma*☐ Adenocarcinoma*☐ LSIL*☐ HSIL*

* indicates additional follow-up required for WWWP

Endometrial biopsy

26. Date performed (MM/DD/CCYY): _____

27. Name – rendering provider (print): _____

28. Result (check one box only)

☐ Negative or normal endometrium☐ Hyperplasia☐ Adenomatous hyperplasia*☐ Atypical Adenomatous hyperplasia*☐ Adenocarcinoma in situ*☐ Adenocarcinoma

* indicates additional follow-up required for WWWP

Section IV: Recommendations and diagnosis

29. Notes

30. Recommendation

- ☐ Follow routine screening schedule _____ months
☐ Short term follow-up _____ months
☐ Further diagnostic work-up
☐ Treatment*

* not covered by WWWP

31. Status of final diagnosis (check one box only):

- | | |
|--|--|
| ☐ Complete* | ☐ Lost to follow-up |
| ☐ Pending | ☐ Refused work-up |
| ☐ Client deceased | |

* must complete element 32 (final diagnosis)

32. Final Diagnosis (required if "complete" is checked in element: 31 status of final diagnosis)

Date performed (MM/DD/CCYY): _____

- | | |
|--|---|
| ☐ Normal, benign, or inflammation | ☐ Invasive cervical cancer** |
| ☐ HPV, condylomata, or atypia | ☐ Adenocarcinoma of the cervix** |
| ☐ CIN1 or mild dysplasia | ☐ LSIL (biopsy diagnosis) |
| ☐ CIN2 or moderate dysplasia* | ☐ HSIL (biopsy diagnosis)* |
| ☐ CIN3, severe dysplasia, or CIS* | |

* **complete treatment date and treatment status**

** **complete treatment date, treatment status, and tumor stage**

33. Tumor stage (AJCC): ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

34. Treatment status (required and check one box only)

- ☐ Treatment started
☐ Refused by client
☐ Lost to follow-up
☐ Not indicated or not needed
☐ Client deceased
☐ Alternative treatment (such as homeopathic therapy or herbal medicine)

35. Treatment date (MM/DD/CCYY): _____