

**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), F-44729A. For reimbursement, send claim plus this completed form to Wisconsin Well Woman Program (WWWP), P.O. 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 Code
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SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth (MM/DD/CCYY)

SECTION III — CERVICAL DIAGNOSTIC PROCEDURES

COLPOSCOPY WITH BIOPSY / ENDOCERVICAL CURETTAGE	COLPOSCOPY WITHOUT BIOPSY
11. Procedure Performed (Check One Box Only) <input type="checkbox"/> Colposcopy with Biopsy <input type="checkbox"/> Endocervical Curettage	21. Date Performed (MM/DD/CCYY)
12. Date Performed (MM/DD/CCYY)	22. Name — Rendering Provider (Print)
13. Name — Rendering Provider (Print)	23. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Abnormality <input type="checkbox"/> Inflammation / Infection / HPV Changes <input type="checkbox"/> Unsatisfactory
14. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Non-malignant Abnormality (HPV, Condyloma) <input type="checkbox"/> CIN 1 / Mild Dysplasia <input type="checkbox"/> CIN 2 / Moderate Dysplasia <input type="checkbox"/> CIN 3 / Severe Dysplasia / CIS <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma	
LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)	COLD KNIFE CONE
15. Date Performed (MM/DD/CCYY)	24. Date Performed (MM/DD/CCYY)
16. Name — Rendering Provider (Print)	25. Name — Rendering Provider (Print)
17. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Non-Malignant Abnormality (HPV, Condyloma) <input type="checkbox"/> CIN 1 / Mild Dysplasia <input type="checkbox"/> CIN 2 / Moderate Dysplasia <input type="checkbox"/> CIN 3 / Severe Dysplasia / CIS <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma	26. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Non-Malignant Abnormality (HPV, Condyloma) <input type="checkbox"/> CIN 1 / Mild Dysplasia <input type="checkbox"/> CIN 2 / Moderate Dysplasia <input type="checkbox"/> CIN 3 / Severe Dysplasia / CIS <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma
ENDOMETRIAL BIOPSY	27. NOTES
18. Date Performed (MM/DD/CCYY)	
19. Name — Rendering Provider (Print)	
20. RESULT (Check One Box Only) <input type="checkbox"/> Negative / Normal Endometrium <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Adenomatous Hyperplasia <input type="checkbox"/> Atypical Adenomatous Hyperplasia <input type="checkbox"/> Adenocarcinoma In-situ <input type="checkbox"/> Adenocarcinoma	

Shading indicates follow up required for WWWP.

28. RECOMMENDATION
 Follow Routine Screening Schedule _____ Months
 Short Term Follow up _____ Months
 Further Diagnostic Work Up
 Treatment*

*Not covered by WWWP.

Continued



SECTION III — CERVICAL DIAGNOSTIC PROCEDURES (Continued)

29. STATUS OF FINAL DIAGNOSIS (Check One Box Only)

- Complete* Pending Member Deceased Lost to Follow up Refused Work-up

*Must complete Element 30 (Final Diagnosis).

30. FINAL DIAGNOSIS (Required)

Date (MM/DD/CCYY) _____

- Normal / Benign / Inflammation HPV / Condyloma / Atypia CIN I / Mild Dysplasia
 CIN 2 / Moderate Dysplasia* CIN 3 / Severe Dysplasia / CIS* Invasive Cervical Cancer**
 Adenocarcinoma of the cervix** LSIL (Biopsy Diagnosis) HSIL (Biopsy Diagnosis)*

*Complete Treatment Date and Treatment Status. **Complete Treatment Date, Treatment Status, and Tumor Stage.

31. TUMOR STAGE (AJCC)

- Stage I Stage II Stage III Stage IV
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32. TREATMENT STATUS — REQUIRED (Check One Box Only)

- Treatment Started
 Refused by Member
 Lost to Follow up
 Not Indicated / Not Needed
 Member Deceased
 Alternative Treatment (e.g., homeopathic therapy, herbal medicine, etc.)
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33. TREATMENT DATE (MM/DD/CCYY)
