DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44729 (11/2023)

STATE OF WISCONSIN
Wis. Stat. § 255.075

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), 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

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 (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 / CIS
- ☐ Invasive Squamous Cell Carcinoma
- ☐ Adenocarcinoma
- ☐ LSIL
- ☐ HSIL

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 / CIS
- ☐ Invasive Squamous Cell Carcinoma
- ☐ Adenocarcinoma
- ☐ LSIL
- ☐ HSIL

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 / HPV Changes
- ☐ Unsatisfactory

Shading 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 / CIS
- ☐ Invasive Squamous Cell Carcinoma
- ☐ Adenocarcinoma
- ☐ LSIL
- ☐ HSIL

LOOP ELECTROSURGICAL EXCISION PROCEDURE	ENDOMETRIAL BIOPSY
17. Date Performed (MM/DD/CCYY)	26. Date Performed (MM/DD/CCYY)
18. Name – Rendering Provider (Print)	27. Name – Rendering Provider (Print)
19. Result (check one box only)	28. 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 / CIS ☐ Invasive Squamous Cell Carcinoma ☐ Adenocarcinoma ☐ LSIL ☐ HSIL	☐ Negative / Normal Endometrium ☐ Hyperplasia ☐ Adenomatous Hyperplasia ☐ Atypical Adenomatous Hyperplasia ☐ Adenocarcinoma in Situ ☐ Adenocarcinoma **Shading 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* ☐ Pending ☐ Client Deceased ☐ Lost to Follow-up ☐ Refused Work-up

***Must complete Element 32 (Final Diagnosis)**

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

Date (MM/DD/CCYY): _____

☐ Normal / Benign / Inflammation	☐ HPV / Condylomata / Atypia	☐ CIN 1 / Mild Dysplasia
☐ CIN 2 / Moderate Dysplasia*	☐ CIN 3 / Severe Dysplasia / CIS*	☐ Invasive Cervical Cancer**
☐ Adenocarcinoma of the Cervix**	☐ LSIL (Biopsy Diagnosis)	☐ HSIL (Biopsy Diagnosis)*

☐ Other: _____

***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 (check one box only)

- ☐ Treatment Started
- ☐ Refused by Client
- ☐ Lost to Follow-up
- ☐ Not Indicated / Not Needed
- ☐ Client Deceased
- ☐ Alternative Treatment (e.g., homeopathic therapy, herbal medicine)

35. Treatment Date (MM/DD/CCYY)

Reset Form