Health Systems Change Clinic Patient Navigation Card for Abnormal Colon Screening

PROVIDER NOTE: **Based on navigation services provided, appropriate information must be completed.**

Medical Record #: _____ Client Date of Birth: _____/_____/_____

Gender: ❑Female ❑Male Client Zip Code: _____

Is client Hispanic/Latina(o) origin? ❑Yes ❑No ❑Unknown

What is the client's race?:
❑American Indian/Alaska Native Tribe _____ ❑Black/African American
❑Mexican American ❑White ❑Asian
❑Pacific Islander/Native Hawaiian ❑Unknown ❑Other_____

Does client have insurance?: ❑Yes ❑No
If yes, is it:
❑Medicare (for people 65+) ❑Part A and B ❑Part A only
❑Medicaid (full coverage for self) ❑Healthcare Insurance Marketplace
❑Private/Employer Insurance

Abnormal Colon Screening

Navigation Guidelines: Women and Men 45 to 74

Screening Test Date for positive FOBT/FIT: ___/___/___
❑FOBT ❑FIT

Diagnostic Test Provided:
❑Colonoscopy

Final Diagnosis:
❑Normal/Negative ❑Polyp No HG Dysplasia
❑Polyp w/HG Dysplasia ❑Cancer

Final Diagnosis Date: ___/___/___

Treatment Start Date: ___/___/___

Structural Barrier Support Assessed and Provided:
❑Transportation ❑Interpretation
❑1:1 Accompaniment ❑Child/Elder Care
❑Extended Hours ❑1:1 Education
❑Partnership Referral ❑Partnership Payment
❑Prep Paid ❑Sample Prep Given

CONTACT #1: _____/_____/_____
By: _____
NOTES:

CONTACT #2: _____/_____/_____
By: _____
NOTES:

_____ _____

Clinician Name *(**PRINT** full name-do not abbreviate)* **Clinic Name** *(**PRINT** full name-do not abbreviate)*

Follow Up Colonoscopy

❑Clinic attesting no financial resources available for coverage

Client First Name: _____

Client Last Name: _____

Date of Colonoscopy: _____/_____/_____

Referred Endoscopy Provider Name: _____

REMINDER:
Please send the CRC Referral Form with the Client

Central Office Use Only:
❑Approved for Data Entry _____

Send completed form to:
Fax: 402-471-0913
Email: dhhs.EWM@nebraska.gov

Health Systems Change Clinic Referral for Colonoscopy

ENDOSCOPY PROVIDER NOTE: This client has been approved to have a follow-up diagnostic colonoscopy through the Nebraska Women's and Men's Health Programs.

CLINIC REFERRAL REMINDER: Please fax this form ***at time of referral*** to (402) 471-0913.

First Name	Initial	Last Name	Date of Birth

This client has been referred by:

❑Bluestem Health
❑Charles Drew Health Center
❑Heartland Health Center
❑Midtown Health Center
❑Nebraska Urban Indian Health Center
❑Community Action Partnership of Western Nebraska
❑Good Neighbor Community Health Center
❑Lincoln Medical Education Partnership
❑One World Community Health Center

Date of positive FOBT/Fit Test: ____/____/____

This client has been referred for: ❑Colonoscopy

Colonoscopy to be performed:
Endoscopy Provider: _____
Address: _____
Date of Colonoscopy: _____/_____/_____ at ___:___ AM/PM

Billing/Admissions/Patient Registration:

1. This form is only used for referred clients and should only be accepted by contracted facilities.
2. The Endoscopy Center can use the top portion of the form for tracking purposes.
3. Send claims to: Women's and Men's Health Programs || 301 Centennial Mall South, P.O. Box 94817 || Lincoln, NE 68509-4817

Client Name: _____ Date of Birth: _____/_____/_____

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Health Systems Change Clinic Patient Navigation Card for Abnormal Breast and/or Cervical Screening

PROVIDER NOTE: **Based on navigation services provided, appropriate information must be completed.**

Medical Record #: _____ Client Date of Birth: _____/_____/_____ Gender: ❑Female ❑Male

Client Zip Code: _____ Is client Hispanic/Latina(o) origin? ❑Yes ❑No ❑Unknown

What is the client's race?:
❑American Indian/Alaska Native Tribe _____
❑Black/African American
❑Mexican American
❑White
❑Asian
❑Pacific Islander/Native Hawaiian
❑Unknown
❑Other_____

Does client have insurance?: ❑Yes ❑No
If yes, is it:
❑Medicare (for people 65+) ❑Part A and B ❑Part A only
❑Medicaid (full coverage for self)
❑Healthcare Insurance Marketplace
❑Private/Employer Insurance

Abnormal Breast Screening

Navigation Guidelines: Women 21 to 74

Screening Test Date: ___/___/___
❑Screening Mammogram ❑Diagnostic Mammogram
❑Clinical Breast Exam ❑MRI-High Risk

Screening Results:
❑Suspicious Abnormality ❑Highly Suggestive
❑Assessment Incomplete

Diagnostic Tests Recommended:
❑Biopsy ❑Cyst Aspiration
❑Diagnostic Mammogram ❑Ultrasound
❑MRI

Final Diagnosis:
❑Cancer-Invasive ❑Not Cancer
❑Lobular Carcinoma In-Situ ❑Ductal Carcinoma In-Situ
❑Atypical Hyperplasia ❑Recurrence

Final Diagnosis Date: ___/___/___
Treatment Start Date: ___/___/___

Structural Barrier Support Assessed and Provided:
❑Transportation ❑Interpretation
❑1:1 Accompaniment ❑Child/Elder Care
❑Extended Hours ❑1:1 Education
❑Partnership Referral ❑Partnership Payment

CONTACT #1: _____/_____/_____ By: _____
NOTES:

CONTACT #2: _____/_____/_____ By: _____
NOTES:

_____
Clinician Name ***(PRINT** full name-do not abbreviation)*

_____
Clinic Name ***(PRINT** full name-do not abbreviate)*

Abnormal Cervical Screening

Navigation Guidelines: Women 21 to 74

Screening Test Date: ___/___/___
❑Pap test with HPV ❑Pap test alone
❑HPV test alone

Screening Results:
❑ASC-US/+HPV ❑Low-grade SIL
❑High-grade SIL ❑Low-grade SIL w/+HPV
❑AGC ❑Low-grade SIL w/-HPV
❑Squamous Cell ❑High Risk HPV
❑ASC-H ❑ASC-H w/+HPV

Diagnostic Tests Recommended:
❑Colposcopy with Biopsy ❑Colposcopy without Biopsy
❑Diagnostic LEEP ❑Other _____

Final Diagnosis:
❑Normal/Benign ❑HPV/Condylomata/Atypical
❑CIN I/Mild Dyspasia ❑CIN II/Moderate Dysplasia
❑CIN III/Severe Dysplasia/Carcinoma
❑Invasive Cervical Carcinoma

Final Diagnosis Date: ___/___/___
Treatment Start Date: ___/___/___

Structural Barrier Support Assessed and Provided:
❑Transportation ❑Interpretation
❑1:1 Accompaniment ❑Child/Elder Care
❑Extended Hours ❑1:1 Education
❑Partnership Referral ❑Partnership Payment

CONTACT #1: _____/_____/_____ By: _____
NOTES:

CONTACT #2: _____/_____/_____ By: _____
NOTES:

Central Office Use Only:
❑Approved for Data Entry _____

Send completed form to: Fax: 402-471-0913
Email: dhhs.EWM@nebraska.gov