

**WISEWOMAN (WW)
Clinical and Billing Form
Instructions on Completion**

PAGE 1 OF 2

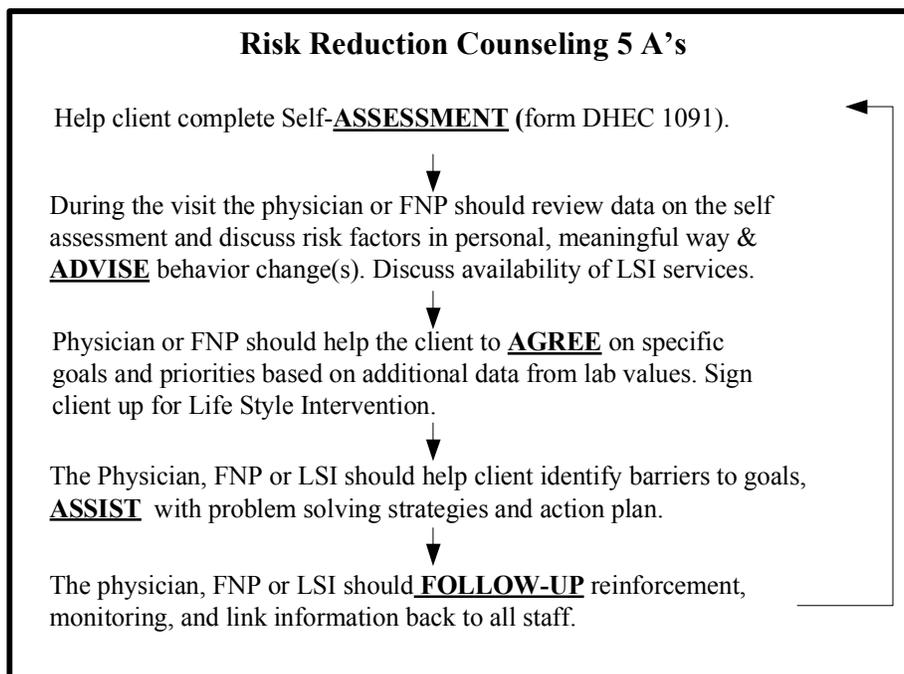
PLEASE PRINT CLEARLY

COMPLETE & SUBMIT THIS FORM WITH PAGE 2
AFTER NEW OR ANNUAL BCN AND WISEWOMAN SCREENING

Purpose: To collect data as required by CDC & DHEC at the initial visit and annually thereafter.

- Provider Label: Please use the label provided by BCN or write in the information that includes: providers unique federal tax number (FTN), contract name, clinical site and provider code (6 digit number assigned by WISEWOMAN)
- A. Demographic and Visit Information Enter the date service as provided – should be the same as the date on BCN Screening/Billing form. Chart number is optional. Check the appropriate services provided. Complete Name, Date of Birth and SSN, if available. Complete highest grade level completed.
- B. Health Assessment Patients should fill out this section if able and staff should assist as necessary. All questions must be answered with only one box checked per question.

Mailing Address is on Page 2 Instructions.



Name: _____ (Last) _____ (First) _____ (Middle)
 SSN or Med-ID: _____ Date of Birth: ____/____/____
MM DD YYYY

This is a report only, LAB results attached: Yes No
 This is a re-visit for counseling (complete counseling section I): Yes No

(Provider Label may be placed here)
Provider FTN:
Contract Facility Name:
Clinic Name:

C. Clinical Measurements

Physical: Ht (ft) ____ (in) ____ Weight (lbs) ____ Waist Circumference (in) ____

Blood Pressure Readings: BP 1st ____/____ BP 2nd ____/____

Cholesterol: Fasting: Yes No Date of Blood Draw: ____/____/____ Adequate blood sample? Yes No
 Client had blood draw At the visit today **ATTACH**
 (check one): 1 – 10 days after initial visit, fasting required **LAB**
 With this health care provider ≤ 30 days prior to the visit today **REPORT**

Glucose or A1C: Glucose Fasting: Yes No Date of Blood Draw: ____/____/____ Adequate blood sample? Yes No
 Client had blood draw At the visit today **If Venipuncture or A1C**
 (check one): 1 – 10 days after initial visit, fasting required **performed and sent to**
 With this health care provider ≤ 30 days prior to the visit today **Lab ATTACH REPORT**
 Client did not have blood draw for Glucose. BG strip performed **in office:** mg/dl ____

D. Clinical Findings **Check one response in each column**

	Blood Pressure	Total Cholesterol	Fasting Glucose	Non Fasting Glucose	A1C%
Normal, no work-up required:	<input type="checkbox"/> SBP <120 and DBP <80	<input type="checkbox"/> < 200	<input type="checkbox"/> 50 - 99	<input type="checkbox"/> ≤ 200	<input type="checkbox"/> ≤ 5.6
Not an Alert value but abnormal, work-up may be required:	<input type="checkbox"/> SBP >120 or > DBP 80	<input type="checkbox"/> 200-399	<input type="checkbox"/> 100-274	<input type="checkbox"/> 200-274	<input type="checkbox"/> ≥ 5.7
Alert value work up required:	<input type="checkbox"/> SBP > 180 or DBP > 110	<input type="checkbox"/> ≥400	<input type="checkbox"/> ≤ 50 or ≥275	<input type="checkbox"/> ≤ 50 or ≥275	

E. Alert Value(s) Follow-Up Status

Complete this section ONLY if client has Alert Value(s)	Blood Pressure	Total Cholesterol	Glucose/A1C
	Status of Alert Follow-up:	<input type="checkbox"/> Complete <input type="checkbox"/> Refused <input type="checkbox"/> Pending <input type="checkbox"/> Lost to F/U	<input type="checkbox"/> Complete <input type="checkbox"/> Refused <input type="checkbox"/> Pending <input type="checkbox"/> Lost to F/U
Date of Alert Follow-up:	____/____/____ <small>MM DD YYYY</small>	____/____/____ <small>MM DD YYYY</small>	____/____/____ <small>MM DD YYYY</small>

F. Physical Activity Clearance

Patient is cleared to begin a physical activity program: Yes No Patient referred to another provider

G. Lifestyle Intervention

Required: Referral to Lifestyle Intervention was completed and mailed to LSI: No Yes
 Client offered information on SC Quit Line: Yes No -Non Smoker

H. Communication to Client (Client must receive results verbally and written)

Client verbally informed of clinical results: No Yes - Date ____/____/____ (MM/DD/YYYY)
 Client mailed or given clinical results: No Yes - Date ____/____/____ (MM/DD/YYYY)

I. Counseling

Client returned to the office for counseling on an **abnormal or alert value(s)** on: ____/____/____
MM DD YYYY
 Client counseled on (check all that apply): Blood Pressure Total Cholesterol Glucose A1C

Date: _____ Signature: _____

**WISEWOMAN (WW)
Clinical and Billing Form
Instructions on Completion**

PAGE 2 OF 2

PLEASE PRINT CLEARLY

- 1) COMPLETE & SUBMIT PAGES 1 & 2 AFTER INITIAL OR ANNUAL WISEWOMAN SCREENING TO SC DHEC-WW
- 2) COMPLETE PAGE 2 ONLY FOR REPORTING LAB RESULTS AND FOR COUNSELING REVISITS PER WW POLICIES. SUBMIT TO SC DHEC - WW
- 3) FAX PAGE 2 ONLY OF WOMEN WITH ALERT VALUES TO DESIGNATED LIFE STYLE INTERVENTIONIST (LSI) AT DHEC AT FAX # PROVIDED WITHIN 2 BUSINESS DAYS
- 4) FAX OR MAIL PAGE 2 ONLY OF ALL OTHER WOMEN (NON-ALERT) TO LSI WITHIN 7 BUSINESS DAYS

**DO NOT SUBMIT FORM WITHOUT RELATED LABORATORY
REPORTS ATTACHED. PAYMENT WILL BE DELAYED IF
APPROPRIATE LABORATORY REPORTS ARE NOT ATTACHED.**

Provider Label: Please use the label provided by BCN or write in the information that includes: provider's unique federal tax number (FTN), contract name, clinical site and provider code (6 digit number assigned by WISEWOMAN)

Demographic and Visit Information Enter the date service as provided – should be the same as the date on BCN Screening/Billing form. Complete Name, Date of Birth and SSN, if available. If reporting Lab results only check Report Only. If a RE-VISIT for counseling client on an ALERT VALUE was completed, check appropriate box.

C. Clinical Measurements Height & Weight Must be completed
TWO blood pressure readings must be completed
Complete fasting status for Cholesterol & Glucose
Attach all Lab Reports

D. Clinical Findings Complete clinical findings section for each service provided

E. Alert Values(s) Follow-Up Status This section is completed **ONLY** if client has an **ALERT** Value

F. Physical Activity Clearance Indicate if the client has been cleared for physical activity – if the screening clinician is unwilling to make this determination, please refer the client to another provider and check appropriate box

G. Lifestyle Intervention Referral to LSI is required. If client is a smoker, check if information was offered on the SC Quit Line

H. Communication to Client Check if client was given clinical results verbally and in writing

I. Counseling If client returned for counseling of an abnormal or alert value, complete date of visit and check the type of finding(s) the client was counseled on

Date and Sign Form