Share the Health Free Gynecology Clinic, Inc.

Share the Health *Mission*

- To improve the health of women with low-income in need of gynecologic specialty care in Dane County and neighboring communities
- To inspire a commitment among future professionals, of all vocations, to care for the underserved in our communities.

Share the Health *Clinic Information*

Conditions Addressed

- Perimenopause and menopause concerns
- Pelvic pain, painful periods, painful intercourse
- Pelvic masses
- Cervical, vulvar, and vaginal lesions
- Abnormal pap smears
- Abnormal uterine bleeding

Eligibility Criteria

- Uninsured women in need of gynecologic specialty care
- 18 years of age and older
- Annual income below 300% of the federal poverty level
- Live in Dane County or bordering counties

300% Federal Poverty Level	
Household Size	Annual Income
1	$35,010
2	$47,190
3	$59,370
4	$71,550
Each additional	$12,180

Clinic Schedule

Clinic is held in the evening on the third Thursday of every month

Clinic Location & Contact Information

5801 Research Park Blvd. Suite 400
Madison, WI 53719
Fax: (608) 729-6390
Phone: (608) 729-6395
Email: ShareTheHealthWI@gmail.com
Website: www.ShareTheHealthWI.org

Referral Instructions

1. Confirm the patient meets required eligibility criteria (listed above).
2. Patient to complete page 1 of the referral forms. **The referral will be denied if this form is not fully completed.**
3. Referring provider or clinic staff should complete pages 2-4 of the referral form.
4. Fax completed referral form to Share the Health at (608) 729-6390.
5. Inform patients they can expect to receive a phone call from Share the Health within 7-10 business days to schedule an appointment.

*** Note: If the referral is not accepted, Share the Health will contact the referring provider within 7-10 business days.*

Resources for conditions not addressed by Share the Health

- *Pregnancy*: Arboretum Obstetrics and Gynecology Clinic (608) 287-5898
- *Annual gyn exam or pap smear*: Wisconsin Well Woman Program (608) 266-8311, Planned Parenthood (800) 230-PLAN
- *Contraception and pregnancy termination:* Planned Parenthood (800) 230-PLAN
- *UTI or other general medicine acute care:* MEDiC Clinics (608) 265-4972

Referral Form- **Share the Health Free Gynecology Clinic**

** Patient to Complete **

Demographic Information

Patient Name:_____ DOB: _____

Address: _____

_____

County: _____

Phone number: _____ Email: _____

Preferred method of contact: _____

The Clinic can leave a phone message:

☐ Yes ☐ No ☐ Only messages pertaining to: _____

Emergency Contact Name: _____

Relation: _____ Phone: _____

Interpreter needed: ☐ Yes ☐ No, Language: _____

Childcare needed: ☐ Yes ☐ No, Number of children: _____

Financial Information

Health Insurance: ☐Yes, _____ ☐No Medical Assistance: ☐Yes ☐No

Employer/Income source: _____ Monthly Income: $_____

Checking Account Balance: $_____ Savings Account Balance: $_____

Social Security: $_____ (monthly benefit)

Other Income: $_____

Total monthly income of your household: $_____

Total number in household: _____

I give Share the Health permission to verify the above information: ☐ Yes ☐ No

I give my employer permission to verify the above information: ☐ Yes ☐ No

My signature certifies that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

STH Use Only: ☐ Approved by _____ **☐ Denied; reason** _____

Referral Form- **Share the Health Free Gynecology Clinic**

** Referring Provider/Staff to Complete **

Patient Name:_____ **DOB:** _____

Referring Provider Information

Date: _____

Referring Provider: _____

Referring Clinic: _____

Clinic Phone Number: _____ Fax Number: _____

Patient Health History

Patient Age: _____

First date of last menstrual period: _____

Last Pap (date/result): _____

Provide a brief description of the reason for referral:

Indicate the <u>primary</u> reason for this referral:

☐ Perimenopause / Menopause concern → Stop here, submit referral

☐ Pelvic pain / Dysmenorrhea / Dyspareunia → Go to and complete #1

☐ Pelvic mass → Go to and complete #2

☐ Cervical / vulvar / vaginal lesion → Go to and complete #3

☐ Abnormal pap → Go to and complete #4

☐ Abnormal Uterine Bleeding → Go to and complete #5

Referral Form- **Share the Health Free Gynecology Clinic**

Patient Name:_____ **DOB:** _____

1. Pelvic Pain / Dysmenorrhea / Dyspareunia

Document prior studies, if completed, and include a copy of reports.

☐ Imaging: _____

☐ Cultures: _____

☐ Biopsies: _____

Stop here, submit referral

2. Pelvic Mass

Document prior studies, if completed, and include a copy of reports.

☐ US: _____

☐ CT: _____

☐ MRI: _____

Stop here, submit referral

3. Cervical / Vulvar / Vaginal Lesions

A. Has a biopsy of this lesion been performed?

☐ Yes → Continue to next question (B)

☐ No → *Stop here, submit referral*

B. Based on the biopsy, is the lesion cancerous?

☐ Yes → Continue to next question (C)

☐ No → *Stop here, submit referral*

C. Please indicate the biopsy results:

☐ Pre-invasive dysplasia, Carcinoma in Situ, or any degree of CIN / VIN / VAIN or Dysplasia → *Stop here, submit referral*

☐ Biopsy confirmed cancer → Refer to UW Cancer Connect – 608-262-5223

Referral Form- **Share the Health Free Gynecology Clinic**

Patient Name:_____ **DOB:** _____

4. Abnormal Pap

A. Has the patient had an abnormal pap within the past 12 months?

☐ Yes → Continue to next questions (B & C)

☐ No → Please perform pap, then complete and submit this referral

B. What were the results of the pap and/or colposcopy? _____

C. Attach results → Physician will review and determine plan of care.

Stop here, submit referral

5. Abnormal Uterine Bleeding

A. Has the patient had any tests for this condition other than a pap smear?

☐ Yes → Test/Result: _____

Attach report and continue to next question

☐ No → Continue to next question (B)

B. Has the patient had a pap smear within the past three years?

☐ Yes → Date/result: _____

Attach report and submit with this referral

☐ No → Please perform pap then submit with this referral form

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Submit completed referral forms to:

Share the Health Fax: (608) 729-6390

Questions? Contact Share the Health:

Phone (608) 729-6395 or ShareTheHealthWI@gmail.com