New Enrollee or Recall Patient: Date of Birth Age

 Client ID # (if applicable)

 ­­­­

*Last Name* *First Name*  *Middle Initial Maiden Name (if applicable)*

 ­­­­­

*Street Address*  City Zip County

( )

*Phone number (cell, home)* Alternate number Best time to contact

*Email address*  *Employer (full time, part time)*

*Social Security # (can be refused)*   *Country of Birth*

Education Level: Marital Status:

Sex: Female Male Spanish or Latino: Yes No Unknown

Race: (Check all that apply): White Black/African American Native American/Indian

 Asian Native Hawaiian or Other Pacific Islander

Household size: Gross Yearly Household income: (***Note: cannot be zero or blank****)*

 ( )

*Emergency Contact*  *Phone number*   *Relationship*

\* \*

*How did you hear about this program Name of referred client and relationship*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Below this line to be completed by CSP-MC staff)

NYSOH Status: Not eligible Cannot afford Chose not to enroll Enrolled, but high copay or deductible is barrier to care Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Health Insurance**: Uninsured

 Medicaid (Monthly spend down $ ) Medicare (Part A only Part A& B )

 Private Deductible Plan Name

 Family Planning Benefit Title X (CVR not submitted & Exam not covered)

 ( ) ( )

(Doctor (GYN, PCP,) Site Code Phone number

 ( ) ( ) ­­­­­

(Specialist (Mammo, GI) Site Code Phone number

*Date of appointment:*

 CBE and/or Pap/Pelvic Mammogram

Patient’s name: Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening History:**

**Breast:**

Previous Mammogram: Yes\_\_\_ No \_\_\_ Unknown \_\_\_\_ Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ (mm/year)

Breast MRI: Yes\_\_\_ No \_\_\_ Unknown \_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ (mm/year)

Previous (CBE): Yes\_\_\_ No \_\_\_ Unknown \_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ (mm/year)

**Cervical:**

Previous Pap Test: Yes \_\_\_No \_\_\_ Unknown \_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ (mm/year)

**Have you had a hysterectomy with cervix removed? Yes \_\_\_ No \_\_\_ Unknown**

**Colorectal:**

Previous FIT Test Yes\_\_\_\_ No \_\_\_ Below 50\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_ (mm/year)

Previous FOBT Test: Yes \_\_\_\_ No \_\_\_Below 50 \_\_\_Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ (mm/year)

Sigmoidoscopy in the last 5 years: Yes \_\_\_No\_\_\_ Unknown Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_ (mm/year)

Colonoscopy in the last 10 years: Yes \_\_\_No \_\_\_Unknown Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_(mm/year)

**Normal \_\_\_\_\_or Abnormal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Recommendation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm)/year)**

**RISK STATUS for Breast, Cervical or Colorectal (B/C/C) cancer: (please circle relevant family member)**

Have you had a previous diagnosis of B/C/C: Yes \_\_\_ No\_\_\_ which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age **\_\_\_, \_\_\_, \_\_\_**

Parent, brother, sister, or child diagnosed with B/C/C: Yes \_\_\_ No \_\_\_ which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_, \_\_\_, \_\_\_

More than one grandparent, aunt or uncle with B/C/C: Yes \_\_\_ No \_\_\_ which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_, \_\_\_, \_\_\_

Family member diagnosed with ovarian cancer: Yes \_\_\_ No \_\_\_ which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_, \_\_\_, \_\_\_

Have you had genetic testing for B/C/C: Yes \_\_\_ No \_\_\_ which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_, \_\_\_, \_\_\_

Ever had a biopsy for B/C/C: Yes \_\_\_ No \_\_\_ which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_, \_\_\_, \_\_\_

Personal history of colon or bowel disease, or polyps: Yes \_\_\_ No \_\_\_ which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_, \_\_\_, \_\_\_ Family history of colon or bowel disease, or polyps: Yes \_\_\_ No \_\_\_ which one\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_, \_\_\_, \_\_\_ Age 50 or older & symptoms of significant bowel or Yes \_\_\_ No \_\_\_

colon problems such as bleeding, mass, or bowel changes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you smoke? Yes \_\_\_ No \_\_\_

Did you ever serve in the Armed Forces? Yes \_\_\_ No \_\_\_

**Referred for Services: (Indicate services this patient is eligible for through CSP-MC)**

Pap and Pelvic Exam: Yes\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_ if No Why?

Clinical Breast Exam: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_ if No Why?

Mammogram: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_ if No Why?

Colorectal Exam: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_ FIT: \_\_\_\_\_\_\_

Immediate Colorectal follow-up not needed: Yes \_\_\_\_ No\_\_\_ Future CRC screening date: (mm/year) March 2016 Page 2 of 2