## Community Colon & Rectal Cancer Screening Form

FOBT#:\_\_\_\_\_\_\_\_\_

## *Men and Women 50-74*

1. **ALL QUESTIONS MUST BE ANSWERED**. Please print clearly.
2. Read and sign
3. Mail the completed test kit in the return envelope provided

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name: Middle Initial:** | | | **Last Name:** | | | | |  | **Maiden Name:** | |
|  | | | | | | | | |  | |
| **Birthdate:** | **Gender** | **Over the age of 50?**  ❑ Yes ❑ No | | **Address:** | | | | | | | |
| / / | ❑ M ❑ F |  | | | | | | | |
| **City:** | | | | | **County:** | | | | | **State: Zip Code:** |
|  | | | | |  | | | | |  |
| **Day Phone:** | | | | | | **Evening Phone:** | | | | | |
| ( ) | | | | | | ( ) | | | | | |
| **In case we can’t reach you:**  **Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_** | | | | | | | **How did you hear about this colon cancer screening program?**  ❑ television ❑ radio ❑ newspaper ❑ friend/relative  ❑ your doctor ❑ your place of work ❑internet ❑Church  ❑ other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **What race or ethnicity are you?**  ❑ American Indian/Alaska Native  ❑ Black/African American  ❑ Asian  ❑ Mexican American  ❑ White  ❑ Pacific Islander/Native Hawaiian  ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Unknown | | | | | | | **Are you of Hispanic/Latina origin?**  ❑ Yes ❑ No ❑ Unknown  Country of Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **What is your primary language?**  ❑ English ❑ Spanish ❑ Vietnamese  ❑ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **What is your household income before taxes?**  ❑ Weekly  ❑ Bi-Weekly Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Monthly  ❑ Yearly  **Please Note:** Self-employed are to use net income after taxes. | | | | | | | **Do you have Health Insurance?**  ❑ Yes ❑ No  (Note: Your health plan will not be billed for this test. Nor will they be notified of your individual test results. ) | | | |
| **How many people live on this income? \_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **Have you ever been screened for colorectal cancer?**  ❑No  ❑ Yes, within the last year  ❑ Yes, more than a year ago  ❑ I don’t know | | | |
| **Who is your primary care doctor?** Name of doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |

***Disclosure Statement***- This test is used only to detect hidden blood in the stool, which can be a sign of several conditions including hemorrhoids, colon polyps, cancer, diverticulitis, ulcers, certain medication and failure to follow dietary instructions. A positive test result means you should contact your family doctor for a follow-up examination. A negative test result does not mean that you do not have cancer. A negative result means you should be screened annually. You should discuss the American Cancer Society’s recommendations for colorectal screenings with your doctor to best determine how often you should be examined

***Authorization to Release Information-*** I hereby authorize the release of my stool test results; the information contained on my registration form and recommended related tests to the testing facility and my doctor. The American Cancer Society is participating in the community awareness campaign for statistical and educational purposes only. This information, as well as patient and physician identity, will be kept strictly confidential and used only for statistical purposes by West Central District Health Department and the Nebraska Colon Cancer Screening Program. The recipient of this patient information is prohibited from disclosing the information to any other party and is required to destroy the information after the need has been fulfilled.

Your Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_