HEALTH DEPARTMENT of Northwest Michigan

Michigan Colorectal Cancer Early Detection Program (MCRCEDP) ENROLLMENT FORM

MBCIS # _____

Enrollment Site or Clinic Name: _____ Date: _____

Client Contact Information – Please PRINT					
Legal Last Name *		**Legal First Name ***		M.I.	
Preferred Name		**Date of Birth ***			
Social Security #		Apt. #		PO Box	
Street Address					
City		**State ***		Zip Code	
County *		Preferred Language			
Phone Number * ( ) Ext.		* □ Home □ Work □ Cell □ Other _____			
Alt Phone # ( ) Ext.		□ Home □ Work □ Cell □ Other _____			
Email Address					
Relationship Status	□ Single □ Married □ Separated □ Divorced □ Widowed □ Partner □ Other _____				
Gender Identity	□ Male □ Female □ Prefer Not to Answer □ Other _____				
Race & Ethnicity *	Are you **Hispanic** or **Latino**? □ Yes □ No □ Unknown □ Prefer Not to Answer				
□ White □ Black/African American □ Asian □ American Indian/Alaskan Native □ Unknown/Did not Answer □ Native Hawaiian/Other Pacific Islander □ Arab/Middle Eastern □ Prefer Not to Answer □ Other _____					

Demographics			
Level of Education: □ Less than high school □ High school graduate □ Some college □ College graduate □ Prefer Not to Answer			
Employment Status: □ Full-time □ Not Employed □ Part Time □ Retired □ Prefer Not to Answer □ Other _____			
Household Members & Income * (*Must be completed for program eligibility*)			
* Client **Yearly Income**		* **Number of people** that the client's yearly income supports *(including client)*	

Provider (Primary Care) Information			
Do you have a regular Primary Care Provider (doctor/nurse practitioner/clinic)? □ No* □ Yes – fill out information below * If NO, client **MUST BE** provided with referral resources for enrollment with a PCP. May we send results of your tests to your Primary Care Provider(s)? □ Yes □ No □ Other _____			
Provider Name		Address	
		Phone	

INSURANCE INFORMATION (bring ALL cards with you) – Please copy both sides of card(s) & retain in patient medical record.					
□ None	□ Insurance Name:				
Contract #:		Group #		Insurance Deductible Amount:	$
□ Yes □ No Referral to **HMP/Medicaid Expansion**		□ Yes □ No Referral to **Marketplace Insurance**			
TOBACCO HISTORY: Do you use any tobacco or smokeless tobacco products? □ Every Day □ Some Days □ Not At All					
Interested in quitting tobacco? □ Yes □ No □ I Don't use Tobacco		Michigan Tobacco QuitLine Referral (FAX sent) □ Yes □ No			
HOW DID YOU LEARN OF THE PROGRAM? □ Primary Care Doctor □ TV/Radio □ Family/Friend □ 2-1-1 Website □ Google/Other web search □ Other _____					

HEALTH DEPARTMENT of Northwest Michigan

Michigan Colorectal Cancer Early Detection Program (MCRCEDP) MEDICAL HISTORY

MBCIS # _____

Clint Name: _____ Date: _____

MEDICAL HISTORY *(Staff must Review this Section with Client)*

Have you ever had any of the following colorectal screening tests: ❑ Yes ❑ No ❑ Unknown

TEST	**DATE** (MM/DD/YYYY)	**RESULTS (check one)**
❑ At home FOBT / FIT / Cologuard	/ /	❑ Normal/Negative ❑ Abnormal/Positive ❑Unknown
❑ Colonoscopy	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown
❑ Sigmoidoscopy	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown
❑ Double Contrast Barium Enema (DCBE)	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown
❑ Other _____	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown

Have you ever been told by a Health Professional that you have:

Crohn's Disease	❑ Yes ❑ No ❑ Unknown
Familial Adenomatous Polyposis (FAP)	❑ Yes ❑ No ❑ Unknown
Lynch Syndrome (HNPCC)	❑ Yes ❑ No ❑ Unknown
Inflammatory Bowel Disease (IBD)	❑ Yes ❑ No ❑ Unknown
Ulcerative Colitis	❑ Yes ❑ No ❑ Unknown

Have you ever been told you have/had colorectal <u>cancer</u>? ❑ Yes ❑ No ❑ Unknown
If yes, Date of Diagnosis? (MM/DD/YYYY) _____/_____/_____ Age:_____

Have you ever been told you have/had colorectal <u>polyps</u>? ❑ Yes ❑ No ❑ Unknown
If yes, Date (MM/DD/YYYY): _____/_____/_____
Were any of the polyps precancerous? ❑ Yes ❑ No ❑ Unknown

Do you have an <u>immediate family member</u> who has ever been diagnosed with colorectal <u>cancer</u>, or precancerous <u>polyps</u>?
❑ Yes ❑ No ❑ Unknown
1) Please check relative: ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Child ❑ Other: _____
Relative(s) Age at Diagnosis: _____ ❑ Colorectal Cancer ❑ Precancerous Polyps
2) Please check relative: ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Child ❑ Other: _____
Relative(s) Age at Diagnosis: _____ ❑ Colorectal Cancer ❑ Precancerous Polyps
3) Please check relative: ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Child ❑ Other: _____
Relative(s) Age at Diagnosis: _____ ❑ Colorectal Cancer ❑ Precancerous Polyps

Are you <u>currently</u> experiencing any of the following? If YES, the client is not eligible for the screening program.

Rectal Bleeding (in the past six months)?	❑ Yes ❑ No ❑ Unknown	Comments:
Blood in your stool (in the past six months)?	❑ Yes ❑ No ❑ Unknown	
Diarrhea (lasting more than 1-2 weeks)?	❑ Yes ❑ No ❑ Unknown	
Constipation (lasting more than 1-2 weeks)?	❑ Yes ❑ No ❑ Unknown	
Unexplained weight loss?	❑ Yes ❑ No ❑ Unknown	
Lower abdominal pain?	❑ Yes ❑ No ❑ Unknown	

PROGRAM STAFF USE ONLY:

Scheduling: Indication for this test: ❑ Screening ❑ Surveillance ❑ Diagnostic (MDHHS Authorization)

Test: ❑ At home FIT ❑ Colonoscopy ❑ Other _____

Date FIT kit distributed to client: (MM/DD/YYYY) _____/_____/_____

**** MUST complete a FIT or Colonoscopy Intake Form ****

POWERED BY CDC SCREENOUTCANCER Colorectal Cancer Control Program

COLORECTAL CANCER Preventable. Treatable. Beatable!

Signature: _____

HEALTH DEPARTMENT of Northwest Michigan

Michigan Colorectal Cancer Early Detection Program
RECORD OF INFORMED CONSENT

The Health Department of Northwest Michigan is offering the Michigan Colorectal Cancer Early Detection Program to eligible, low income men and women who are age 50-64, uninsured or underinsured, at average or increased risk for colorectal cancer and not currently enrolled in the Healthy Michigan Plan.

Purpose of the Michigan Colorectal Cancer Early Detection Program
The purpose of the Program is to prevent or find out if I have cancer of the colon or the rectum (gut or colorectal cancer). Regular cancer screening tests can help find a cancer early, when it is still very treatable. If cancer is found before it spreads to other parts of the body, my chances for survival are much better. If cancer is found, I will be helped to find cancer treatment.

What Will I Get From the Program?

1. **Colonoscopy**
   - The program provides a colonoscopy which is a screening test for cancer of the colon (gut and rectum).

2. **Fecal Immunochemical Test (FIT) At-Home-Test**
   - If I am at average risk for colorectal cancer, I may choose to complete a FIT test **every year at-home** instead. The test checks for blood in my stool (poop) that I may not be able to see with my eyes. Within a week, I must use a special "kit" to collect a small sample of stool, and immediately mail the sample to the lab in the special envelope provided in the kit.
   - Blood in my stool is not normal. It can be there because of cancer or because of other problems.
   - If the FIT kit finds blood in my stool, I understand I will also need a colonoscopy. A colonoscopy is necessary and must be completed to determine why there is blood in my stool.

What Will the Program Cost Me? **INITIALS** _____.

- The Program will pay for a colonoscopy and a "prep" to clean out my gut before the test.
- The Program will pay for biopsies and to have polyps (small mushroom-like growths) removed during the colonoscopy, if needed. There may be other costs not covered by this program.
- My provider may want me to get other tests or services not covered by the Program; **these tests will not be paid by the Program.** If I agree to get these other tests, I will have to pay for these extra tests or services myself. I understand that I can ask program staff any questions I have about what is paid for by the program.
- The program will also pay for the FIT stool test for colorectal cancer screening if I am at average risk for colorectal cancer. If blood is found in my stool, I will need a second test, a colonoscopy. The staff will help schedule the colonoscopy and the MCRCEDP will pay for this necessary test.

When I enroll in the Program, I will be asked if I have health insurance. I am eligible to receive Program services only if am uninsured or underinsured and **not enrolled in** the Healthy MI Plan.

- If I receive program services and I did not tell the truth about my insurance status, I will be responsible for all costs of program services that I have received.

HEALTH DEPARTMENT of Northwest Michigan

What Happens If My Tests Are Not Normal? **INITIALS**_____

- If I have a test that is not normal, my provider will tell me what test they think I need next. It is my choice to have more tests.
- If I have another provider, I can give the Program written permission to send my test results to the provider.

What if I have Colorectal Cancer? **INITIALS**_____

- I understand the Program does not pay for treatment for colorectal cancer such as, but not limited to: Surgery, Chemotherapy, Radiation, Medications, or Home Health Care.
- If colorectal cancer is found, the Program staff will help me find a provider and cancer treatment.
- If I cannot pay for follow-up services or cancer treatment, the Program staff will work with me to help me find the services I need.

Things I need to Know about the Screening Tests **INITIALS**_____

- The risks associated with the screening tests are low, but do exist.
- The MCRCEDP staff, providers and their staff will answer my questions about screening tests and risks.
- I may ask questions at any time.
- No screening test is 100 % correct. Screening tests can sometimes miss something that is not normal. Sometimes tests may think something is a problem when it is OK.
- It is important that I receive screenings regularly. Cancer can develop later even if my test results today are normal.
- If my screening test is not normal, it does not always mean that I have cancer. After more tests, only some men and women will be diagnosed with cancer.

I AGREE TO: **INITIALS**_____

- ☐ Follow the Program staff's directions and complete the FIT.
- ☐ Follow the Program staff's directions and complete the prep and colonoscopy.
- Be contacted when it is time to schedule my next screening appointment.
- Repeat these screening tests at the times the provider thinks is best.
- Be contacted if more testing or appointments are necessary.

I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll. The (Agency) phone number is (_____/_____-_____)

_____ _____

Signature of Client Date

_____ _____

Signature of Person Obtaining Informed Consent Date

CONTENTS OF THIS FORM REMAIN IN EFFECT UNTIL MY NEXT ANNUAL VISIT
MICHIGAN COLORECTAL CANCER EARLY DETECTION PROGRAM

HEALTH DEPARTMENT of Northwest Michigan

MICHIGAN COLORECTAL CANCER EARLY DETECTION PROGRAM (MCRCEDP)
RELEASE OF INFORMATION

I UNDERSTAND THAT:

- Any personal information found about me will be kept confidential.
- Only information about me that does not identify me will be used in grouped reports or for other scientific purposes concerned with controlling colorectal cancer.
- I may be asked some time in the next several years to answer questions about my colorectal health, or my experiences with this screening program. I understand I am not required to answer such questions. If I do, I do not have to identify myself.

I GIVE PERMISSION AND AGREE TO:

- Provide the Program Agency with information about me, including my health history and reports of screening and diagnostic tests and procedures relating to colorectal cancer.
- Allow the Program Agency to give information regarding my care to:
    - My physician/health care provider
    - Any consulting physician
    - Any clinic or hospital where I may be referred
    - Any other individual chosen by me
    - The Michigan Department of Health and Human Services and other State Of Michigan departments.

I have been able to ask questions about this program and this form, and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll in the MCRCEDP.
The MCRCEDP Agency phone number is (_____/_____-_____).

Signature of client date

Signature of person obtaining informed consent date

CONTENTS OF THIS FORM REMAIN IN EFFECT ONE YEAR FROM DATE SIGNED