BC3NP Enrollment Form

Enrollment / Clinic Site: _____ Enrollment Date: _____

Client Contact Information – Please Print					
Last Name		**First Name**		M.I.	
Date of Birth		**Social Security # :**			
What sex were you assigned at birth? Or what is on your birth certificate?	☐ Female ☐ Male				
What is your Gender Identity *(Check one)*	☐ Female ☐ Male ☐ Transgender woman / Transgender female ☐ Transgender man / Transgender male ☐ Something else (e.g., queer, pansexual, asexual _____) ☐ Do not know ☐ Choose not to disclose				
Do you identify as *(Check one)*	☐ Straight or heterosexual ☐ Lesbian, gay, homosexual ☐ Bisexual ☐ Something else (e.g., queer, pansexual, asexual, _____) ☐ Do not know ☐ Choose not to disclose				
Street Address		Apt. #		PO Box	
City		**State**		**Zip Code**	
County		Preferred Language			
Phone Number		☐ **Home** ☐ Work ☐ **Cell** ☐ Other			
Email Address					
☐ I do **not** wish to receive communications from BC3NP local coordinating agency (LCAs) and / or MDHHS.					
*** Race and Ethnicity** (*Check all that apply*)	Are you **Hispanic** or **Latino**? ☐ Yes ☐ No ☐ Unknown ☐ Prefer Not to Answer				
☐ White ☐ Black / African American ☐ Asian ☐ Arab / Arab American ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Other Pacific Islander ☐ Prefer not to answer ☐ Unknown / did not Answer					
What services do you need? (*Check all that apply*)	☐ Mammogram ☐ Follow-up for an abnormal Mammogram and / or breast exam (a.k.a. diagnostics) ☐ Pap test ☐ HPV test ☐ Follow-up for an abnormal Pap test and / or HPV test (a.k.a. diagnostics)				
Barriers Identified Do you need help with any of the following to receive services? (*Check all that apply*)	☐ No problems ☐ Help with scheduling appointments ☐ No health care provider ☐ Problems getting time off work ☐ Insurance Issues ☐ Transportation ☐ Family Care Issues ☐ Language/Translation Services needed ☐ Education on screening/diagnostic procedures ☐ Other _____				
Demographics					
Level of Education: ☐ Less than high school ☐ High school graduate ☐ Some college ☐ College graduate ☐ Prefer not to answer ☐ Other _____					
Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Other _____					
Employment Status: ☐ Full-time ☐ Not employed ☐ Part time ☐ Retired ☐ Prefer not to answer ☐ Other _____					
*** Household Members and Income** (Must be completed for program eligibility)					
*** Yearly Income**		*** Number of people** that the client's yearly income supports (including client)			

BC3NP Medical History and Risk Assessment Form

Patient Name: _____ Birth Date: _____

Breast History

Previous Mammogram? ☐ No ☐ Yes: Date: _____ Previous CBE? ☐ No ☐ Yes: Date: _____

Previous Breast Biopsy? ☐ No ☐ Yes: Date: _____

Have you been told you are at High-Risk for developing breast cancer? ☐ No ☐ Yes

Have you received an MRI for being at High-Risk for developing breast cancer? ☐ No ☐ Yes: Date: _____

Breast Cancer Risk *Checking at least one of the below indicates increased/high-risk for breast cancer.*

☐ **NO Risk => Average** (Mamm Only) ☐ **Unknown** – assmt compl, clt answ "I don't know" (Mamm Only) ☐ **Not Assessed** (Mamm Only)

☐ Personal history/family member with BRCA/another gene mutation

☐ Personal lifetime risk of ≥ 20-25% or > 1.7 % (Gail model)

☐ Radiation treatment to the chest between ages 10-30

☐ History of atypical hyperplasia or Lobular carcinoma in situ ☐ Personal/family history of genetic syndromes

*** HIGH-RISK – Contact MDHHS for approval of MRI***

☐ Personal/family history of ovarian cancer ☐ 3 or more family members with breast cancer

☐ Family member diagnosed with breast cancer under age 50

☐ Other: _____

***AVERAGE-RISK – May be at high-risk - contact MDHHS for approval of MRI ***

Cervical History

Previous Pap Test? ☐ No ☐ Yes: Date: _____ Previous HPV Test? ☐ No ☐ Yes: Date: _____

History of Hysterectomy? ☐ No ☐ Yes: Date: _____ Do you have a cervix? ☐ No ☐ Yes ☐ Unknown

Reason for Hysterectomy? ☐ Pre-cervical cancer ☐ Cervical cancer ☐ Other: _____

Cervical Cancer Risk *Checking at least one of the below indicates high-risk for cervical cancer.*

☐ **NO Risk => Average** (Regular scrn) ☐ **Unknown** – assmt compl, clt answ "I don't know" (Regular scrn) ☐ **Not Assessed** (Regular scrn)

☐ Prior history of pre-cervical cancer or cervical cancer ☐ Prior DES exposure ☐ HIV/AIDS infection

☐ Organ transplantation ☐ Immunosuppression from other causes ☐ Other: _____

Personal Cancer History

☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal ☐ Other Cancer: _____ Year: _____

Family History of Cancer

☐ Yes (Complete information below.) ☐ No ☐ Unknown

Relationship 1: ☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt ☐ Father ☐ Brother ☐ Grandfather ☐ Uncle

Relation Type 1: ☐ Maternal ☐ Paternal Age _____ **Cancer 1:** ☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

Relationship 2: ☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt ☐ Father ☐ Brother ☐ Grandfather ☐ Uncle

Relation Type 2: ☐ Maternal ☐ Paternal Age _____ **Cancer 2:** ☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

Tobacco History

Do you use any tobacco or smokeless tobacco products?

☐ Every day ☐ Some days ☐ Not at all

Interested in quitting tobacco?

☐ Yes ☐ No ☐ Don't use tobacco

Michigan Tobacco Quitline Referral (Fax sent) ☐ Yes ☐ No

(To be completed by the enrollment site/agency/clinic.)

Comments