



# RE-SCREEN

## Department of Public Health and Social Services Guam Breast and Cervical Cancer Early Detection Program

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### ELIGIBILITY AND CONSENT FORM

#### Eligibility Worksheet

Primary Physician/Clinic

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) Age: \_\_\_\_ Marital Status: \_\_\_\_ Place of Birth: \_\_\_\_\_

Occupation \_\_\_\_\_ SS#: \_\_\_\_\_ Home Tel. No: \_\_\_\_\_ Other Tel. No: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Citizenship:  US  Qualified Alien Documented Resident:  Yes  No

Insurance Coverage: \_\_\_\_\_ Family Size: \_\_\_\_\_ Gross Income: \$ \_\_\_\_\_  Monthly  Annually

#### Breast History

Date of last mammogram: \_\_\_\_\_ Facility: \_\_\_\_\_

Breast symptoms?  No  Yes If Yes: \_\_\_\_\_ (specify)

Family history of breast cancer?  No  Yes If Yes: \_\_\_\_\_ (who)

Mastectomy?  No  Yes If Yes, side: \_\_\_\_\_

Reconstructed?  No  Yes

#### Cervical History

Date of last Pap test: \_\_\_\_\_ Facility: \_\_\_\_\_

Cervical symptoms?  No  Yes If Yes: \_\_\_\_\_ (specify)

Hysterectomy?  No  Yes If Yes: \_\_\_\_\_ (reason)

Is cervix present?  No  Yes  Unknown

Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Unknown

#### Tobacco Use History:

- 1) Do you use tobacco?  Yes  No, If yes mark as appropriate:  Smoke  Chew  Dip/Snuff
- 2) Do you plan to quit?  Yes, if yes  Quit Date (within 30 days) \_\_\_\_/\_\_\_\_/\_\_\_\_  No, Not Ready to Quit
- 3) Does anyone in your family *smoke cigarettes*?  Yes  No

#### Consent for Participation, Release of Information and Statement of Confidentiality

I have been informed about all the services covered by the Program that does not include treatment for cancer diagnosed and that all available resources may be used to notify me if I have any abnormal results. By agreeing to participate in the GBCCEDP, I authorize to all of my doctors, health care providers, clinics, and/or hospital the release of any medical and other information necessary to the Program to ensure timely and appropriate screening and diagnostic follow-up and treatment; I give my consent for the Program to coordinate my care and services as needed, and to be screened at the Program's outreach site; I agree to have a mammogram, breast exam, Pap test annually or as recommended and any diagnostic services (program funded) determined necessary. I understand that the GBCCEDP will not hold liable for any complications that may occur during the screening or diagnostic procedures performed at the health care providers, clinics or hospital

I understand that any information given to the GBCCEDP will be confidential, which means that the information will be used to meet the objective of the Program and any published reports by the Program will not identify me by name.

I certify that all information that I have provided is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Signature of Staff: \_\_\_\_\_ Date: \_\_\_\_\_

Eligibility Status: Eligible  New  Re-screening  ⇒ ⇒  B&C  B only  C only  
Not Eligible  Reason: \_\_\_\_\_