

BCCCNP ENROLLMENT FORM

To be completed by
Clinic Staff:
 New Patient
 Returning Patient


Enrollment/Clinic Site: _____ Enrollment Date: _____

CLIENT CONTACT INFORMATION – Please PRINT					
Last Name *				MBCIS or ID#:	
First Name *		Preferred Name		M.I.	
Maiden Name		Date of Birth *			
Social Security # (SSN is used for billing/payment only.):					
Gender Identity		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> Other _____			
Street Address		Apt. #		PO Box	
City		State *		Zip Code	
County *		Preferred Language			
Phone Number * ☎		() Ext.	* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Text <input type="checkbox"/> Other _____		
Alt Phone # ☎		() Ext.	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Text <input type="checkbox"/> Other _____		
Email Address ✉					
COMMENTS ~ for agency or clinic use					
*RACE & ETHNICITY "Select all that apply"		Are you Hispanic or Latino ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer Not to Answer			
		<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Unknown/Did not Answer <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Arab/Middle Eastern <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> Other _____			
BARRIERS IDENTIFIED		<input type="checkbox"/> None <input type="checkbox"/> Trouble scheduling appointments <input type="checkbox"/> No health care provider <input type="checkbox"/> Getting time off work <input type="checkbox"/> Insurance Issues <input type="checkbox"/> Transportation <input type="checkbox"/> Family Care Issues <input type="checkbox"/> Education on Screening/Diagnostic Svcs <input type="checkbox"/> Language/Translation <input type="checkbox"/> Other _____			
DEMOGRAPHICS					
Level of Education: <input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate <input type="checkbox"/> Some college <input type="checkbox"/> College graduate <input type="checkbox"/> Prefer Not to Answer					
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partner <input type="checkbox"/> _____					
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Not Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> 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)	
INSURANCE INFORMATION (bring ALL cards with you) - Please fax copy of card to program & retain in patient medical record					
<input type="checkbox"/> No Insurance – Eligible for BCCCNP		<input type="checkbox"/> Referred to HMP/Medicaid Expansion		<input type="checkbox"/> Referred to ACA Marketplace Insurance	
COMMENTS ~ for agency or clinic use					
HOW DID YOU LEARN OF THE PROGRAM? <input type="checkbox"/> Primary Care Doctor <input type="checkbox"/> TV/Radio <input type="checkbox"/> Family/Friend <input type="checkbox"/> 2-1-1 Website <input type="checkbox"/> Google/Other web search <input type="checkbox"/> Other _____					

**BCCCNP MEDICAL HISTORY &
RISK ASSESSMENT FORM**

MBCIS # _____

Patient Name: _____ Enrollment Date: _____

MEDICAL HISTORY <i>(Clinician must Review this Section with Client)</i>		Client DOB: / /
BREAST EXAM HISTORY		
Previous Mammogram? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: mm / dd / yyyy	Previous Clinical Breast Exam (CBE)? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: mm / dd / yyyy	Previous Breast Biopsy? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: mm / dd / yyyy
BREAST CANCER RISK		
Client at <u>High Risk</u> for <u>BREAST</u> cancer if <u>any of the following is checked</u> : <input type="checkbox"/> Personal history/Family Member with BRCA/another gene mutation <input type="checkbox"/> Personal lifetime risk of ≥ 20 -25% or > 1.7 % (Gail model) based on risk assessment models <input type="checkbox"/> Radiation treatment to the chest between ages 10-30 <input type="checkbox"/> History of atypical hyperplasia or Lobular carcinoma in situ <input type="checkbox"/> Personal/family history of genetic syndromes (Li-Fraumeni syndrome) <input type="checkbox"/> Other: _____		Client at high risk for <u>BREAST</u> cancer? <input type="checkbox"/> YES => High / Increased Risk (Screening mammogram & Screening MRI – preapproval required) <input type="checkbox"/> NO => Average (Mammogram Only) <input type="checkbox"/> * Unknown (Mammogram Only) *Risk was assessed, but client answers “I don’t know” <input type="checkbox"/> Not Assessed (Mammogram Only)
CERVICAL TEST HISTORY		
Previous Pap Test? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes: Date: mm / dd / yyyy	Previous HPV Test? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes: Date: mm / dd / yyyy	
History of Hysterectomy? <input type="checkbox"/> No <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Yes: Date: mm / dd / yyyy	Reason for Hysterectomy? <input type="checkbox"/> Pre-cervical cancer <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Other: _____	Do you have a cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
CERVICAL CANCER RISK		
Client at <u>High Risk</u> for <u>CERVICAL</u> cancer if <u>any of the following is checked</u> : <input type="checkbox"/> Prior history of CIN 2, CIN 3, or cervical cancer <input type="checkbox"/> Prior DES exposure <input type="checkbox"/> Immunosuppression for other causes <input type="checkbox"/> HIV/AIDS infection <input type="checkbox"/> Organ transplantation <input type="checkbox"/> Other: _____		Client at high risk for <u>CERVICAL</u> cancer? <input type="checkbox"/> YES => High / Increased Risk (Pap test (alone) annually for 3 years. If normal, then Pap/HPV Co-test every 3 yrs) <input type="checkbox"/> NO => Average (Regular screening) <input type="checkbox"/> * Unknown (Regular screening) *Risk was assessed, but client answers “I don’t know” <input type="checkbox"/> Not Assessed (Regular screening)
PERSONAL CANCER HISTORY		
<input type="checkbox"/> BREAST Cancer: Year Diagnosed: _____ <input type="checkbox"/> CERVICAL Cancer: Year Diagnosed: _____ <input type="checkbox"/> OVARIAN Cancer: Year Diagnosed: _____	<input type="checkbox"/> COLORECTAL Cancer: Year Diagnosed: _____ <input type="checkbox"/> OTHER Cancer: Year Diagnosed: _____	
FAMILY HISTORY OF CANCER		
Have any of your relatives been diagnosed with breast, cervical, ovarian, and/or colorectal cancer? <input type="checkbox"/> Yes <i>(Complete information below)</i> <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Relationship1: <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Daughter <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle <input type="checkbox"/> Son		
Relation Type1: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Age: _____	Cancer Type1: <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Ovarian <input type="checkbox"/> Colorectal
Relationship2: <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Daughter <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle <input type="checkbox"/> Son		
Relation Type2: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Age: _____	Cancer Type2: <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Ovarian <input type="checkbox"/> Colorectal
TOBACCO HISTORY 		
Do you use any tobacco or smokeless tobacco products? <input type="checkbox"/> Every Day <input type="checkbox"/> Some Days <input type="checkbox"/> Not At All		
Interested in quitting tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't use Tobacco		Michigan Tobacco QuitLine Referral (FAX sent) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(to be completed by the enrollment site/agency/clinic)</i>