

Client Name: _____

Social Security Number: _____

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Screening Program (MCSP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana men and women can be screened through this program for colorectal cancer and women can also receive breast and cervical cancer screenings. Each time a client is screened for colorectal cancer, they may receive either an FOBT/FIT test or a colonoscopy. If any of the initial tests for colorectal cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic colonoscopy and/or biopsy of colon tissue. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCSP will provide case management services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCSP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered

The MCSP only provides services for colorectal, breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCSP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCSP.

Insurance Information

I understand I have met the eligibility guidelines for the MCSP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCSP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCSP staff. The MCSP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCSP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCSP staff, my health care provider(s), the laboratory reading my FIT and/or Pap smear, and the radiology facility where my mammogram is performed with respect to MCSP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCSP and agree to participate in the program. I have had an opportunity to ask question about the MCSP and have received answers to any question I had. All information, including financial and insurance benefits, I have provided to the MCSP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCSP at any time.

Client Signature: _____

Date: _____
MM / DD / YYYY

Print Full Name: _____



Colorectal Eligibility & Enrollment Form



Last Name		First Name		Middle Initial	Other Last Names Used (If Applicable)
Birth date MM / DD / YYYY	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number - -		State	County
Mailing Address				City	Zip
Family Income before Taxes		Number of People in Household		Home/Cell Phone	Work Phone
Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have health insurance that might cover these services? <input type="checkbox"/> Yes <input type="checkbox"/> No		Insurance Company	
Ethnic Background Are you Hispanic? (<i>Spanish/ Hispanic / Latino</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Race: Check all races that apply. <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian /Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black/African American				How did you hear about the program? Please check all that apply. <input type="checkbox"/> Doctor <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> NBCCEDP/Colorectal Program <input type="checkbox"/> TV <input type="checkbox"/> Mailing Flyer <input type="checkbox"/> Magazine Article <input type="checkbox"/> Radio <input type="checkbox"/> Family Member <input type="checkbox"/> Community Event <input type="checkbox"/> Other	

Do you use tobacco? – If yes, refer the client to the MT Quit Line.

***** Office Use Only *****

Screening History/Risk Assessment				-----Test result-----						
Enter data on the colorectal screening tests the client has had.				Normal / Negative	Normal/ Negative/ results other than polpy(s)/ tumor(s) or cancer	Abnormal / Positive	Polyp(s) / tumor(s) /cancer	Incomplete	Unknown	
Test	Date MM/YYYY	Client had test								
		Yes	No	Unknown						
CRC Fecal take-home FOBT/FIT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>
Stool DNA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Sigmoidoscopy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DCBE) Double Contrast Barium Enema		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(CTC) Virtual Colonoscopy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes No Unknown **Have you been diagnosed with colorectal cancer or precancerous polyps?**
 Yes No Unknown **Has a blood relative been diagnosed with colorectal cancer or precancerous polyps?**

Are you currently experiencing colorectal cancer symptoms? <input type="checkbox"/> Rectal bleeding, dark stool, blood in the stool within the past 6 months. <input type="checkbox"/> Prolonged change in bowel habits: diarrhea/constipation for more than 2 weeks. <input type="checkbox"/> Persistent abdominal pain. <input type="checkbox"/> Symptoms of bowel obstruction, abdominal distension, nausea, vomiting. <input type="checkbox"/> Significant unintentional weight loss of 10% or more of starting body weight.	Have you been diagnosed with or are you being treated for <input type="checkbox"/> A genetic diagnosis of familial Adenomatous Polyposis (FAP) or Hereditary Non Polyposis Colorectal Cancer (HNPCC)? <input type="checkbox"/> A clinical diagnosis or suspicion of FAP or HNPCC? <input type="checkbox"/> Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis)?
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Client Signed Informed Consent.

Admin Site # _____ **State ID** _____

Eligibility Determined by: _____ **Date Eligible:** _____