BCCCNP
Breast and Cervical Cancer Control Navigation Program

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	□ Male □ Female □ Prefer Not to Answer □ Other _____					
Street Address		Apt. #		PO Box		
City		**State ***		Zip Code		
County *		Preferred Language				
Phone Number *	Ext.	* □ Home □ Work □ Cell □ Text □ Other _____				
Alt Phone #	Ext.	□ Home □ Work □ Cell □ Text □ Other _____				
Email Address						
COMMENTS ~ *for agency or clinic use*						
***RACE & ETHNICITY** *"Select all that apply"*	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 _____						
BARRIERS IDENTIFIED	□ None □ Trouble scheduling appointments □ No health care provider □ Getting time off work □ Insurance Issues □ Transportation □ Family Care Issues □ Education on Screening/Diagnostic Svcs □ Language/Translation □ Other _____					

DEMOGRAPHICS
Level of Education: □ Less than high school □ High school graduate □ Some college □ College graduate □ Prefer Not to Answer
Relationship Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Partner □ _____
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)*	

INSURANCE INFORMATION *(bring ALL cards with you)* - Please fax copy of card to program & retain in patient medical record		
□ **No Insurance** – Eligible for BCCCNP	□ Referred to **HMP/Medicaid Expansion**	□ Referred to **ACA Marketplace Insurance**
COMMENTS ~ *for agency or clinic use*		
HOW DID YOU LEARN OF THE PROGRAM? □ Primary Care Doctor □ TV/Radio □ Family/Friend □ 2-1-1 Website □ Google/Other web search □ Other _____		

POWERED BY CDC
SCREENOUTCANCER
National Breast & Cervical Cancer Early Detection Program

BCCCNP
Breast and Cervical Cancer Control Navigation Program

BCCCNP MEDICAL HISTORY & RISK ASSESSMENT FORM

MBCIS # _____

Patient Name: _____ Enrollment Date: _____

MEDICAL HISTORY *(Clinician must Review this Section with Client)* Client DOB: / /

BREAST EXAM HISTORY

Previous Mammogram?	Previous Clinical Breast Exam (CBE)?	Previous Breast Biopsy?
☐ No	☐ No	☐ No
☐ Yes: Date:	☐ Yes: Date:	☐ Yes: Date:

BREAST CANCER RISK

Client at High Risk for BREAST cancer if any of the following is checked:

☐ Personal history/Family Member with BRCA/another gene mutation

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

☐ Radiation treatment to the chest between ages 10-30

☐ History of atypical hyperplasia or Lobular carcinoma in situ

☐ Personal/family history of genetic syndromes (Li-Fraumeni syndrome)

☐ Other: _____

Client at high risk for BREAST cancer?

☐ **YES => High / Increased Risk**
(Screening mammogram & Screening MRI – preapproval required)

☐ NO => **Average** (Mammogram Only)

☐ * **Unknown** (Mammogram Only)
*Risk was assessed, but client answers "I don't know"

☐ **Not Assessed** (Mammogram Only)

CERVICAL TEST HISTORY

Previous Pap Test? ☐ No ☐ Unknown
☐ Yes: Date:

Previous HPV Test? ☐ No ☐ Unknown
☐ Yes: Date:

History of Hysterectomy?	Reason for Hysterectomy?	Do you have a cervix?
☐ No ☐ Full ☐ Partial	☐ Pre-cervical cancer ☐ Cervical cancer	☐ Yes
☐ Yes: Date:	☐ Other: _____	☐ No ☐ Unknown

CERVICAL CANCER RISK

Client at High Risk for CERVICAL cancer if any of the following is checked:

☐ Prior history of CIN 2, CIN 3, or cervical cancer

☐ Prior DES exposure

☐ Immunosuppression for other causes

☐ HIV/AIDS infection

☐ Organ transplantation

☐ Other_____

Client at high risk for CERVICAL cancer?

☐ **YES => High / Increased Risk**
(Pap test (alone) annually for 3 years. If normal, then Pap/HPV Co-test every 3 yrs)

☐ NO => **Average** (Regular screening)

☐ * **Unknown** (Regular screening)
*Risk was assessed, but client answers "I don't know"

☐ **Not Assessed** (Regular screening)

PERSONAL CANCER HISTORY

☐ BREAST Cancer: Year Diagnosed: _____
☐ CERVICAL Cancer: Year Diagnosed: _____
☐ OVARIAN Cancer: Year Diagnosed: _____
☐ COLORECTAL Cancer: Year Diagnosed: _____
☐ OTHER Cancer: Year Diagnosed: _____
_____

FAMILY HISTORY OF CANCER

Have any of your relatives been diagnosed with breast, cervical, ovarian, and/or colorectal cancer?
☐ Yes (*Complete information below*) ☐ No ☐ Unknown

Relationship1: ☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt ☐ Daughter ☐ Father ☐ Brother ☐ Grandfather ☐ Uncle ☐ Son

Relation Type1: ☐ Maternal ☐ Paternal	Age		**Cancer Type1**: ☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

Relationship2: ☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt ☐ Daughter ☐ Father ☐ Brother ☐ Grandfather ☐ Uncle ☐ Son

Relation Type2: ☐ Maternal ☐ Paternal	Age		**Cancer Type2**: ☐ 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)*

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