P2

The Iowa Breast & Cervical Cancer Early Detection Program

Genesis Visiting Nurse Association
611 No. 2nd St. Clinton, IA 52732
563-244-4925

Dear ,

I'm glad you've chosen to participate in the Clinton County Breast and Cervical Cancer Early Detection (BCC) program. Enclosed are forms for you to complete, sign and return in the enclosed envelope. Because the state program has made significant changes (intented to include a cardiovascular screen during your visit) there are more questions for you to answer. When an answer has an arrow, which points to more questions, please answer those questions as well.

Enclosed is your pink BCC enrollment card, which will be activated when we receive your completed forms.

When you make your clinic appointment:

1. **Tell the receptionist that it will be a BCC Program exam.**
2. **Call** (563-244-4925) **with your BCC appt. date and location**

Your BCC appointments:

1. **Present your pink BCC enrollment card each time you check-in for your appointments** (in order for the program to be billed for your BCC approved services). Only the services, which are checked, will be covered through the BCC Program.
2. **Keep me informed of your appointment dates.**
3. Call if you have any abnormal results, or if you have any billing issues; additional tests may be covered by the BCC Program.
4. Also call if you have any questions or if you are in doubt about what is covered by this program.

Sincerely,

Dona Bark RN, BCCEDP Coordinator

clip here and attach to other forms

Please complete the questions in this box and return with other forms:

1. Clinic/physician of choice ______________________ **Appointment date**(s): ________________
2. Your current height __________________
3. When was your last mammogram? _______________ Pap? ______________

Iowa Breast and Cervical Cancer Early Detection Program

Informed Consent and Release of Medical Information

Program # 23 Client # ______________ Date of Birth ____/____/______

Name ________________________________ Phone (_____) ______-________
PLEASE PRINT

Address ____
STREET CITY STATE ZIP

- * Read and sign this consent and release to show that you know what it means and agree to it.
- * Read about program services on the back of this consent.
- * Sign this consent to be part of the *Care for Yourself* program.

1. I want to be a part of the *Care for Yourself* Program. This program screens women for breast and cervical cancer. To be part of the program I know I must be 40 years old or older or have symptoms of breast cancer, earn less than set income guidelines, and not have Medicare Part B coverage.
2. Being part of this program is my choice. I can tell the *Care for Yourself* staff if I no longer want to be part of the program.

PLEASE contact your local coordinator right away if you need further tests or treatment or have any questions.

Dona Bark
(Local Coordinator Name)
563-244-4925
(Phone Number)

3. I have talked with the clinic staff about how I will pay for tests or services not covered by *Care for Yourself.*
4. I accept responsibility for following advice my doctor may give me.
5. I give permission for my doctor, laboratory, clinic, radiology unit and/or hospital to provide the *Care for Yourself* program results of my breast and cervical cancer screening exams, follow-up exams and treatment. This includes results for program services provided within one year of the date below.
6. *Care for Yourself* will use my name, address, and other personal information to remind me of screening or follow-up exams, and to help me find treatment.
7. *Care for Yourself* and the Centers for Disease Control and Prevention (CDC) may approve studies to help researchers learn about women's health. My name will not be used. My information will be combined with other women's information before it is shared.
8. Please contact the person listed below, who does not live with me, if you can not reach me with important information about my health.

Name ________________________ Phone ______________ Relationship __________

Address ____
STREET CITY STATE ZIP

9. I release this program and its employees and agents from any claims, demands, and actions related to my participation in *Care for Yourself.* This includes any claims related to a failure to detect or diagnose cancer, failure of treatment, or any acts or omissions related to diagnosis or treatment while I am part of the program.

______________________________ ______________
Client Signature Date

HIPAA allows for disclosure of protected health information to public health authorities for public health activities.

White – Program Yellow – Client Revised 11/08

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from the following Genesis Health System Affiliated Entity:

- ☐ DeWitt Community Hospital
- ☐ Family Medical Clinic
- ☐ FirstMed Clinics
- ☐ FirstMed Pharmacy
- ☐ Genesis Behavioral Resources
  - ☐ Genesis Workplace Services
  - ☐ Psychology Associates
- ☐ Genesis Employee Assistance Program
- ☐ Genesis Health Group
- ☐ Other ____________________
- ☐ Genesis Health Services Foundation
- ☐ Genesis Medical Center
- ☐ Genesis Medical Education Foundation, Inc
- ☐ Family Medical Center
- ☐ GenVentures
  - ☐ ContinuingCare Specialists
  - ☐ Passport Health
- ☐ Illini Convenient Care
- ☐ Illini Health Care, Inc.
- ☐ Illini Hospital
- ☐ Illini Hospital Foundation
- ☐ Illini Nursing Home
- ☐ Illini Restorative Care
- ☐ Illini Sheltered Care
- ☑ Visiting Nurse Association (VNA)
  - ☑ Genesis VNA
  - ☐ Illini Home Health Care
  - ☑ Clinton County VNA
  - ☐ Hospice Care of VNA

______________________________ Patient Signature

______________________________ Date Signed

______________________________ Signature of Patient Representative

______________________________ Date Signed

BEST EFFORT TO OBTAIN ACKNOWLEDGEMENT

Follow Up Date	Type of Follow Up F = Face-to-Face T = Telephone M = Mail	Follow Up By	Comments

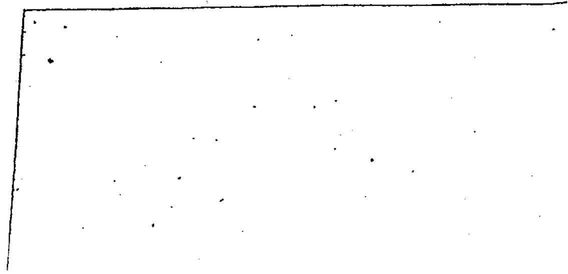
REASON ACKNOWLEDGEMENT NOT RECEIVED

The patient, after best effort, did not acknowledge receipt of a Notice of Privacy Practices from the Genesis Health System Affiliated Entity noted above due to the following reason (s):

- ☐ Patient refused to sign acknowledgement form
- ☐ Patient expired
- ☐ Unable to locate patient
- ☐ Patient unconscious
- ☐ Other: (Specify) ____________________

______________________________ Signature

______________________________ Date Signed



Client Identification

Complete this form once per year at annual enrollment.
Please PRINT all information.

1. Program # ___ ___ ___
2. Client # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
3. Today's Date ___ ___/___ ___/___ ___ ___ ___ *(mm / dd / yyyy)*
4. Last Name ______________________________
5. First Name ______________________________ 6. Middle Initial _____
7. Address ______________________________
8. City ______________________________
9. State ___ ___ 10. Zip ___ ___ ___ ___ ___ 11. County of Residence ___ ___ ___ *(001-099, or 111 for outside Iowa)*
12. Phone (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Client Demographic Information

13. First time **ever** enrolled in the Iowa Care for Yourself program?
  - ○ 1. Yes
  - ○ 2. No *(continue with questions 14-17)*

13a. Birth Date ___ ___/___ ___/___ ___ ___ ___ *(mm / dd / yyyy)*

13b. Maiden Name ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

13c. Hispanic or Latina Origin?
○ 1. Yes ○ 2. No ○ 3. Unknown

Please answer 13d-13i to identify your race

Yes	No	Unknown	
○	○	○	13d. White
○	○	○	13e. Black or African American
○	○	○	13f. American Indian or Alaska Native
○	○	○	13g. Asian
○	○	○	13h. Native Hawaiian or Other Pacific Islander
○	○	○	13i. Some other race

(Continue with questions 14-17)

14. Health Insurance
  - ○ 1. None
  - ○ 2. Private Insurance
  - ○ 3. Medicare A *(not Part B)*
  - ○ 4. Other

15. Monthly Income $___, ___ ___ ___

16. Family Unit Size ___ ___

17. Education *(check highest level attained)*
  - ○ 1. Less than 9th grade
  - ○ 2. Some high school
  - ○ 3. High school graduate or equivalent
  - ○ 4. Some college or higher
  - ○ 5. Don't know
  - ○ 6. Don't want to answer

Client Medical History

18. Have you had breast cancer?
○ 1. Yes ○ 2. No ○ 3. Don't know

19. Has your mother, grandmother, aunt, sister, or daughter had breast cancer?
○ 1. Yes ○ 2. No ○ 3. Don't know

20. Have you had a hysterectomy?
  - ○ 1. Yes →
    - 20a. Due to cervical cancer? → ○ 1. Yes ○ 2. No ○ 3. Don't know
    - 20b. Cervix present? → ○ 1. Yes ○ 2. No ○ 3. Don't know
  - ○ 2. No
  - ○ 3. Don't know

21. Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?
  - ○ 1. Yes
  - ○ 2. No
  - ○ 3. Don't know
  - ○ 4. Don't want to answer

22. Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?
  - ○ 1. Yes
  - ○ 2. No
  - ○ 3. Don't know
  - ○ 4. Don't want to answer

Client Identification

Program # __ __ __ Last name ______________ Today's Date __ __/__ __/__ __ __ __ (mm / dd / yyyy)

Client # __ __ __ __ __ __ __ __ __ __ First Name ______________ Middle Initial ______

Client Medical History (continued)

23. Have you ever been told by a doctor, nurse, or other health professional that you have diabetes?
    - ◯ 1. Yes
    - ◯ 2. No
    - ◯ 3. Don't know
    - ◯ 4. Don't want to answer
24. Has a doctor, nurse, or other health professional ever told you that you had any of the following: heart attack (also called myocardial infarction), angina, coronary heart disease, or stroke?
    - ◯ 1. Yes
    - ◯ 2. No
    - ◯ 3. Don't know
    - ◯ 4. Don't want to answer
25. Has your father, brother, or son had a stroke or heart attack before age 55?
    - ◯ 1. Yes
    - ◯ 2. No
    - ◯ 3. Don't know
    - ◯ 4. Don't want to answer
26. Has your mother, sister, or daughter had a stroke or heart attack before age 65?
    - ◯ 1. Yes
    - ◯ 2. No
    - ◯ 3. Don't know
    - ◯ 4. Don't want to answer
27. Has either of your parents, your brother or sister, or your child ever been told by a doctor, nurse, or other health professional that he or she has diabetes?
    - ◯ 1. Yes
    - ◯ 2. No
    - ◯ 3. Don't know
    - ◯ 4. Don't want to answer

Client Medication History

28. Are you currently taking medication for high cholesterol?
    - ◯ 1. Yes, as prescribed
    - ◯ 2. Yes, but did not take today
    - ◯ 3. No
    - ◯ 4. Don't know
    - ◯ 5. Don't want to answer
29. Are you currently taking medication for high blood pressure?
    - ◯ 1. Yes, as prescribed
    - ◯ 2. Yes, but did not take today
    - ◯ 3. No
    - ◯ 4. Don't know
    - ◯ 5. Don't want to answer
30. Are you currently taking medication for diabetes?
    - ◯ 1. Yes, as prescribed
    - ◯ 2. Yes, but did not take today
    - ◯ 3. No
    - ◯ 4. Don't know
    - ◯ 5. Don't want to answer

Client Smoking History

31. Do you now smoke cigarettes?
    - ◯ 1. Every day
    - ◯ 2. Some days
    - ◯ 3. Not at all →
    - ◯ 4. Don't know
    - ◯ 5. Don't want to answer

31a. Are you a former smoker?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know
- ◯ 4. Don't want to answer

For office use only:

31b. Client was:
- ◯ 1. Referred to a proactive Quitline
- ◯ 2. Referred to a community-based cessation program
- ◯ 3. Provided Quitline contact information