



FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION SCREENING PROGRAM
PATIENT ENROLLMENT/REFERRAL FORM (PRF)

The Florida Department of Health in Putnam County invites you to take part in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). If you qualify, you may receive your breast and cervical cancer examinations. If your test results are not normal, FBCCEDP will work with your doctors to help you obtain additional tests and, if needed, treatment.

There may be some cost to you for some tests if you have abnormal results and need diagnostics or treatment. Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties

IDENTIFICATION/GENERAL INFORMATION

All fields must be completed for application to be processed.

NAME:

_____ Last _____ First _____ MI _____

Mailing ADDRESS:

_____ Street _____ City _____ Zip _____ County _____
Street ADDRESS:

_____ Street _____ City _____ Zip _____ County _____
PHONE: (_____) _____ - _____ **Other** Contact Phone _____

SSN: _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____ **AGE:** _____

Tobacco Use 1) Daily 2) Some Days 3) Not at all 4) Declined to answer

We offer a free smoking cessation program. Would you be interested in entering our smoking cessation program?

Yes No

BREAST EXAM BACKGROUND (Check only one box for each category)

Have you yourself ever been diagnosed with BREAST CANCER? ____ YES (year _____) ____ NO

Implants: Yes/No? How long? _____

Family Hx: Yes/No? **Circle:** Grandma/Grandpa Mother/Father/Aunt/Sister/Brother?

When was your last MAMMOGRAM: (month _____ /year _____) ____ NONE ____ Unsure (5+ years?)

Where was it done? (PROVIDER) _____

CERVICAL EXAM BACKGROUND

Have you yourself ever been diagnosed with invasive cervical CANCER? ____ YES (year _____) ____ NO

When was your last PAP SMEAR exam (month _____ /year _____) ____ NONE ____ Unsure (5+ years?)

HYSTERECTOMY Yes/No (Partial/full) When? _____

Cervix Yes/No?

Note: Partial Hysterectomy the cervix or cervical stump is present.



Height _____ (inches) Weight _____ BP ____/____ Hx of Hypertension / High Blood Pressure? Yes/ No?
 Diabetes? Yes? No? Type: _____

PROGRAM DATA: RACE – Check or circle ALL that apply:

- AMERICAN INDIAN or ALASKAN NATIVE ASIAN BLACK/AFRICAN AMERICAN
- NATIVE HAWAIIAN or Other PACIFIC ISLANDER WHITE
- OTHER (PLEASE DEFINE) _____

PRIMARY LANGUAGE: ENGLISH / SPANISH

ETHNICITY: HISPANIC OR LATINO? YES / NO.

INCOME/INSURANCE INFORMATION: *(Required information. Please check or circle all that apply.)*

Check if you are receiving any of the following:
 Medicare A **Yes/No** Medicare B **Yes/No** Medicaid **Yes/No**
 Do you have **any** health insurance? **YES** _____ **NO** _____
Type _____ **NO** _____

Number in Household _____
Monthly Income _____
Annual Income _____
Unemployment _____

Client Agreement

- I understand that no test is 100% accurate.
- This statement is true at the time it is made. I understand that the provider shall attempt to verify the statement. Verification can be secured by telephone, in written form, or by face-to-face contact; verification does not require a written document to confirm an applicant or client's statement. If the provider is unable to verify wages paid or an employer will not verify wages paid, the signed self-declaration statement provided by the applicant must be accepted as accurate.
- I have read or had the above read to me. I agree that the information I have provided is correct.

Client Signature: _____

Date: _____

Please Print Name: _____

Referred By: _____

PLEASE ATTACH ANNUAL APPLICATION AGREEMENT FORM SIGNED AND DATED. THANK YOU!

Do you have a preference of facility/physician? Yes /No If yes, where or who? _____

Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

- I agree to become a client of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP).
- Florida is my primary residence.
- I declare that my net family annual income is at or below 200% of the federal poverty guideline and I have no health insurance that pays for breast and cervical cancer screening exams.
- I understand I am no longer eligible for the FBCCEDP if my income changes to be above 200% of the federal poverty guideline or if I enroll in any health insurance program that provides breast and cervical cancer screening.
- I understand that I may have a share of cost for some services.
- I agree to use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test) and I agree to complete any follow-up tests within 60 days.
- I understand that the FBCCEDP is a breast and cervical cancer **screening** program, not a cancer **treatment** program. If I am diagnosed with breast or cervical cancer as a result of my FBCCEDP screening, I will be referred to a provider for my cancer treatment. I understand I can reapply to the FBCCEDP for screenings after initial treatment is completed.
- I agree to allow an exchange and release of information via fax or mail between my health care providers, the Florida Department of Health Breast and Cervical Cancer Early Detection Program, the Florida Department of Health Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination results, and any follow up tests and treatments done as a result of the examination, even if the tests or treatment I receive are not paid for by the FBCCEDP.
- I agree to receive phone or mail contact from FBCCEDP staff about my health care.
- I understand this agreement is good for one year unless my program eligibility changes.
- I understand that taking part in this program is my choice and I may withdraw from the program at any time.

Client signature

Date

Printed name

Date of birth

Revised 04/2014





AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

- | | | |
|--|--|---|
| <input type="checkbox"/> General Medical Record(s), including STD and TB | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> History and Physical Results |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Family Planning | <input type="checkbox"/> Prenatal Records |
| <input type="checkbox"/> Diagnostic Test Reports (Specify Type of test(s) _____) | | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Other: (specify) _____ | | |

I specifically authorize release of information relating to: (initial selection)

- | | |
|--|--|
| <input type="checkbox"/> HIV test results for non-treatment purposes | <input type="checkbox"/> Substance Abuse Service Provider Client Records |
| <input type="checkbox"/> Psychiatric, Psychological or Psychotherapeutic notes | <input type="checkbox"/> Early Intervention |
| | <input type="checkbox"/> WIC |

PURPOSE OF DISCLOSURE:

Continuity of Care Personal Use Other (specify) _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOICATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

Client/Representative Signature

Date

Printed Name

Representative's Relationship to Client

Witness (optional)

Date

Client Name: _____

ID#: _____

DOB: _____