



BC3NP Enrollment Form

Enrollment / Clinic Site: _____ Enrollment Date: _____

Client Contact Information – Please Print					
Last Name		First Name		M.I.	
Date of Birth		Social Security # :			
What sex were you assigned at birth? Or what is on your birth certificate?				<input type="checkbox"/> Female <input type="checkbox"/> Male	
What is your Gender Identity <i>(Check one)</i>		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender woman / Transgender female <input type="checkbox"/> Transgender man / Transgender male <input type="checkbox"/> Something else (e.g., queer, pansexual, asexual _____) <input type="checkbox"/> Do not know <input type="checkbox"/> Choose not to disclose			
Do you identify as <i>(Check one)</i>		<input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian, gay, homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else (e.g., queer, pansexual, asexual, _____) <input type="checkbox"/> Do not know <input type="checkbox"/> Choose not to disclose			
Street Address		Apt. #		PO Box	
City		State		Zip Code	
County		Preferred Language			
Phone Number		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Other			
Email Address					
<input type="checkbox"/> I do not wish to receive communications from BC3NP local coordinating agency (LCAs) and / or MDHHS.					
* Race and Ethnicity <i>(Check all that apply)</i>		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"/> Arab / Arab American <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown / did not Answer					
What services do you need? <i>(Check all that apply)</i>		<input type="checkbox"/> Mammogram <input type="checkbox"/> Follow-up for an abnormal Mammogram and / or breast exam (a.k.a. diagnostics) <input type="checkbox"/> Pap test <input type="checkbox"/> HPV test <input type="checkbox"/> Follow-up for an abnormal Pap test and / or HPV test (a.k.a. diagnostics)			
Barriers Identified Do you need help with any of the following to receive services? <i>(Check all that apply)</i>		<input type="checkbox"/> No problems <input type="checkbox"/> Help with scheduling appointments <input type="checkbox"/> No health care provider <input type="checkbox"/> Problems getting time off work <input type="checkbox"/> Insurance Issues <input type="checkbox"/> Transportation <input type="checkbox"/> Family Care Issues <input type="checkbox"/> Language/Translation Services needed <input type="checkbox"/> Education on screening/diagnostic procedures <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 <input type="checkbox"/> Other _____					
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"/> Other _____					
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 and Income (Must be completed for program eligibility)					
* Yearly Income		* Number of people that the client's yearly income supports (including client)			

BC3NP Medical History and Risk Assessment Form

Patient Name: _____ Birth Date: _____

Breast History	
Previous Mammogram? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: _____ Previous CBE? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: _____ Previous Breast Biopsy? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: _____ Have you been told you are at High-Risk for developing breast cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes Have you received an MRI for being at High-Risk for developing breast cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: _____	
Breast Cancer Risk <i>Checking at least one of the below indicates increased/high-risk for breast cancer.</i>	
<input type="checkbox"/> NO Risk => Average (Mamm Only) <input type="checkbox"/> Unknown – assmt compl, clt answ “I don’t know” (Mamm Only) <input type="checkbox"/> Not Assessed (Mamm Only)	
<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) <input type="checkbox"/> Radiation treatment to the chest between ages 10-30 <input type="checkbox"/> History of atypical hyperplasia or Lobular carcinoma in situ	<p style="text-align: center; margin: 0;">* HIGH-RISK – Contact MDHHS for approval of MRI*</p>
<input type="checkbox"/> Personal/family history of ovarian cancer <input type="checkbox"/> 3 or more family members with breast cancer <input type="checkbox"/> Family member diagnosed with breast cancer under age 50 <input type="checkbox"/> Other: _____	<p style="text-align: center; margin: 0;">*AVERAGE-RISK – May be at high-risk - contact MDHHS for approval of MRI *</p>
Cervical History	
Previous Pap Test? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: _____ Previous HPV Test? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: _____ History of Hysterectomy? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date: _____ Do you have a cervix? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Reason for Hysterectomy? <input type="checkbox"/> Pre-cervical cancer <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Other: _____	
Cervical Cancer Risk <i>Checking at least one of the below indicates high-risk for cervical cancer.</i>	
<input type="checkbox"/> NO Risk => Average (Regular scrn) <input type="checkbox"/> Unknown – assmt compl, clt answ “I don’t know” (Regular scrn) <input type="checkbox"/> Not Assessed (Regular scrn) <input type="checkbox"/> Prior history of pre-cervical cancer or cervical cancer <input type="checkbox"/> Prior DES exposure <input type="checkbox"/> HIV/AIDS infection <input type="checkbox"/> Organ transplantation <input type="checkbox"/> Immunosuppression from other causes <input type="checkbox"/> Other: _____	
Personal Cancer History	
<input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Ovarian <input type="checkbox"/> Colorectal <input type="checkbox"/> Other Cancer: _____ Year: _____	
Family History of Cancer	
<input type="checkbox"/> Yes (Complete information below.) <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Relationship 1: <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle Relation Type 1: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal Age _____ Cancer 1: <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Ovarian <input type="checkbox"/> Colorectal	
Relationship 2: <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle Relation Type 2: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal Age _____ Cancer 2: <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 (To be completed by the enrollment site/agency/clinic.)
Comments	