**Pre-registration Screening Form**

**Eligible: \_\_\_\_\_\_\_ Pap \_\_\_\_\_\_\_\_\_\_Mammogram (after review of information)**

1. **Are you between the ages of 21-64? Yes or No ( if no, not eligible for the program)**

**2a. Do you have health insurance? Yes or No – If Yes, ask**

**2b. Was there a time in the past 12 months when you needed to see a doctor but could not because you could not afford it? Yes or No**

|  |  |
| --- | --- |
| **Name****(Last, First)** |  |
| **Age & DOB****mm/dd/yyyy** |  |
| **Last 4 SS#****full number needed if chosen** |  |
| **Address** | **Street:** |
| **City:** | **Zip:** |
| **County:** |
| **Phone: Cell: Other:** |
| **Email:** |
| **Preferred Language** | **Interpreter needed?****Yes No** | **If yes, Language:** |
| **Marital status** | **Never married Married widowed separated divorced** |
| **Have you or a family member ever been diagnosed with cervical cancer?** | **If you have been diagnosed with cervical cancer when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_****What treatment did you have?****Where did you have the treatment?****What was the result****If a family member, who?** |
| **Have you or a family member ever been diagnosed with breast cancer** | **Yes No****If yes, who:** |
| **Race: What term do you feel best describes your race?** | **White** | **Black** | **Asian** | **American Indian** |
| **Pacific Islander** | **Other** | **Refused to answer** |
| **Ethnicity:** | **Are you of Hispanic, Latino, or Spanish origin, such as Mexican, Puerto Rican or Cuban? Yes or No** |
| **Emergency Contact** | **Name** |
| **Relationship** | **Phone Number** |
| **Transportation** | **Do you have reliable transportation? Yes or No****If no: Will you need transportation assistance if selected for screening? Yes or No** |
| **When was your last Pap test?** | **PAP TEST ELIGIBILITY****Women ages 21 to 64 who:*** **Never had a Pap test**
* **No Pap test within the last three years (since Month Year)**
* **Abnormal Pap test results**

**ADDITIONAL QUESTIONS****Have you ever had a pap test? Yes or No****Have you had a hysterectomy? Yes or No****Comments:****Have you ever had an abnormal Pap smear? Yes or No****Comments:****Pap eligible? Yes or No** |
| **When was your last mammogram?** | **Mammogram eligibility****Women 40 and over*** **Never had a mammogram**
* **No mammogram within the last year (since Month Year)**
* **No visible lumps or lesions**

**ADDITIONAL QUESTIONS (Y or N)**1. **Are you 40 years of age or older**

**Yes – eligible****No – not eligible**1. **Have you ever had a mammogram?**

**Yes or no**1. **Has it been at least a year since your last mammogram?**

**Yes – eligible****No – not eligible**1. **Do you have breast implants?**

**Yes – not eligible****No - eligible**1. **Are you pregnant?**

**Yes – not eligible****No - eligible**1. **Are you breastfeeding?**

**Yes – not eligible****No - eligible**1. **Are you having any problems such as lumps or dimpling?**

**Yes – refer to Dr. for diagnostic exam****No – eligible****Diagnostic exam is free if they qualify for financial assistance**1. **Hav your ever had breast cancer?**

**No – eligible****Yes – have you received a mastectomy or a lumpectomy?****If yes mastectomy, the healthy breast can be screened****If yes lumpectomy, cannot be screened****Mammogram Eligible? Yes or No****Mammogram only (no Pap) ? Yes or No** |
| **Reviewed by coordinator: \_\_\_\_\_** | **Date:****Eligible for \_\_\_\_\_\_\_\_\_\_\_\_ Pap \_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram** |

**If selected your information will be shared with a Health center based on your home address where you can/will be enrolled in the Mississippi Breast and Cervical Cancer Program which will allow for any needed follow-up of possible abnormal findings!**