NEW ENROLLEE

Department of Public Health and Social Services

Guam Breast and Cervical Cancer Early Detection Program

Tel: 735-0670/1/2, 735-0675/95 * Fax: 734-7626
123 Chalan Kareta, Route 10, Mangilao, Guam *96913-6304*

Eligibility Worksheet

Enrollment Site: _____ Date: _____ SS#: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ / _____ / _____ (MM/DD/YYYY) Age: ____ Marital Status: _____ Occupation _____

Citizenship: ☐ US ☐ Qualified Alien Documented Resident: ☐ Yes ☐ No

Race: ☐ Chamorro ☐ Black ☐ Chuukese ☐ Palauan ☐ White
☐ Filipino ☐ Hispanic ☐ Other Pacific Islander: _____ (specify)
☐ Other Asian: _____(specify) ☐ Other: _____ (specify)

Place of Birth: _____

Mailing Address: _____ Home Address: _____

Daytime Phone: _____ Nighttime Phone: _____

Source of Referral: ☐ BCCP Reminder ☐ Self ☐ Family/Friend
☐ Provider ☐ Outreach ☐ GOMH
☐ Brochure ☐ Poster:_____(specify location)
☐ TV / Radio / Newspaper ☐ Other: _____(specify)

Insurance Coverage: _____ Family Size: _____ Gross Income: $ _____ ☐ Monthly ☐ Annually

Breast History

Breast symptoms? ☐No ☐Yes If Yes: _____(specify)
Family history of breast cancer? ☐No ☐Yes If Yes: _____(who)
Mastectomy? ☐No ☐Yes If Yes, side: _____
Reconstructed? ☐No ☐Yes
****
Number of mammogram in the last 5 years: _____
Previous mammo? ☐No ☐Yes Date : ___/___/_____
Result: _____ Facility: _____
Address:_____
Paid bv BCCEDP? ☐Yes ☐No ☐Unknown

Cervical History

Cervical symptoms? ☐No ☐Yes If Yes: _____ (specify)
Hysterectomy? ☐No ☐Yes If Yes: _____ (reason)
Is cervix present? ☐No ☐Yes ☐Unknown
Date of last menstrual period: ___/___/_____
****
Number of Pap test in the last 5 years: _____
Previous Pap? ☐No ☐Yes Date : ___/___/_____
Result: _____ Facility: _____
Address:_____
Paid by BCCEDP? ☐Yes ☐No ☐Unknown

Tobacco Use History:

1) Do you use tobacco? ☐ Yes ☐ No, If yes mark as appropriate: ☐ Smoke ☐ Chew ☐ Dip/Snuff
2) Do you plan to quit? ☐ Yes, if yes ☐ Quit Date (within 30 days) ___/___/___ ☐ No, Not Ready to Quit
3) Does anyone in your family *smoke cigarettes*? ☐ Yes ☐ No
4) Referred for intervention? ☐ Yes ☐ No If yes, (specify): _____

Consent for Participation, Release of Information and Statement of Confidentiality

I have been informed about all the services covered by the Program that does not include treatment for cancer diagnosed and that all available resources may be used to notify me if I have any abnormal results. By agreeing to participate in the GBCCEDP, I authorize to all of my doctors, health care providers, clinics, and/or hospital the release of any medical and other information necessary to the Program to ensure timely and appropriate screening and diagnostic follow-up and treatment; I give my consent for the Program to coordinate my care and services as needed, and to be screened at the Program's outreach site; I agree to have a mammogram, breast exam, Pap test annually or as recommended and any diagnostic services (program funded) determined necessary.

I understand that any information given to the GBCCEDP will be confidential, which means that the information will be used to meet the objective of the Program and any published reports by the Program will not identify me by name.

I certify that all information that I have provided is true and correct.

Signature: _____ Date: _____

Name and Signature of Staff: _____ Date: _____

Eligibility Status: Eligible ☐ New ☐ Re-screening ⇒⇒ ☐ *B&C* ☐ *B only* ☐ *C only*
Not Eligible ☐ Reason: _____