

(For Office Use Only) Date: ____/____/____ Participant ID _____

Eligible ☐ Not Eligible ☐ Research Consent ☐
Screening ☐ Diagnostic ☐ Treatment ☐
Clinic/Clinic Referral ☐ Community Setting ☐



Event name: _____

Date: _____

BEATRICE W. WELTERS BREAST HEALTH OUTREACH AND NAVIGATION PROGRAM

HEALTH SCREENER

Age: ☐ Less than 40 ☐ 40-44 ☐ 45-49 ☐ 50-54 ☐ 55-74 ☐ 75 and older

Zip Code: _____ Ethnicity: ☐ Black ☐ Hispanic ☐ White ☐ Other

What is your current gender identity?

☐ Male ☐ Female ☐ Trans Man ☐ Trans Woman ☐ Gender-Queer ☐ Other

About Cancer Screening:

Mammogram in the last year: ☐ Yes ☐ No ☐ Don't know

Do you have Medical Insurance? ☐ Yes ☐ No ☐ Don't Know

Have you taken the COVID-19 vaccine? ☐ Yes, Date: _____ ☐ No

Are you interested in receiving navigational services to assist with getting a mammogram screening? ☐ Yes ☐ No

Would you like to receive information about cancer prevention programs, services and research?

☐ Yes ☐ No Cell Phone: _____

NAVIGATION INTAKE FORM

I have been provided information on the Welters Breast Health Outreach and Navigation Program and I consent to enroll:

Signature

Date

Name: _____

Pronouns: ☐ She/her/hers ☐ He/ him/his ☐ They/them/theirs ☐ Other: _____

Date of Birth: ____/____/____

Address: _____ Apt #: _____

City: _____ State: _____ ZIP Code: _____

Mailing Address (if different): _____

Home Phone: _____ Cell Phone: _____

May we text you on your Cell Phone: ☐ Yes ☐ No

Work Phone: _____ Email Address: _____

Best Time(s) to Call: _____ Best Day(s) to Call: _____

May we leave a message? ☐ Yes ☐ No

Emergency Contact: _____ Phone Number: _____

Which of the following categories best describes you?

- | | | |
|--|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> West-Indian American (of | <input type="checkbox"/> Asian or Pacific Islander |
| <input type="checkbox"/> Black | African descent) | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Black American | <input type="checkbox"/> Caribbean (of African descent) | |
| <input type="checkbox"/> African | <input type="checkbox"/> Caribbean-American (of | <input type="checkbox"/> Other (<i>please specify</i>) |
| <input type="checkbox"/> African American | African descent) | _____ |
| <input type="checkbox"/> West Indian (of African | <input type="checkbox"/> Afro-Caribbean | |
| descent) | <input type="checkbox"/> American Indian | |

What is the highest grade or year of school you have completed?

- | | |
|---|---|
| <input type="checkbox"/> Never attended school or only kindergarten | <input type="checkbox"/> Some college |
| <input type="checkbox"/> Grades 1-8 (Elementary) | <input type="checkbox"/> College graduate (4+ yrs.) |
| <input type="checkbox"/> Grades 9-11 | <input type="checkbox"/> Post College |
| <input type="checkbox"/> High school graduate or GED | |

If applicable, are you taking any hormones? ☐ Yes ☐ No If yes, for how long? _____

Have you had any gender-affirming surgeries? ☐ Yes ☐ No

If yes, what kind(s) _____ Date: ____/____/____

What is your current sexual orientation or practice?

☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Asexual ☐ Choose not to disclose

Date of Previous Cancer Screening?

Clinical Breast Exam ☐ Yes ☐ No

Date: ____/____/____

Mammogram: ____/____/____

Where: _____ Where? _____

Have you ever been told by a doctor that you have cancer? ☐ Yes ☐ No

If yes, what type of cancer _____

When were you diagnosed? _____

Where were you treated? _____

Has a family member ever been diagnosed with cancer? ☐ Yes ☐ No

<u>Family Member</u>	<u>Type of Cancer</u>	<u>Age at diagnosis</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

History of abnormal breast findings/diagnostic mammo/ultrasound? ☐ Yes ☐ No

Date: ____/____/____

Where? _____

Do you have a primary health care provider? ☐ Yes ☐ No

Type of Insurance: ☐ Private ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid _____

*Explain research project. Participant consented to research: ☐ Yes ☐ No