

Stomach Cancer Prevention Screening Form

Ver. 06/23/20

Completed By: _____

Date: ____/____/____

EHR Eligibility Verification

Completed By: _____ Date: ____/____/____

H. pylori positive (ICD 9/10 code _____) ☐ No

☐ Yes → By: C-urea breath test, histology, rapid urease test,
or bacterial culture

Age 21 or older ☐ Yes ☐ No

Eligible: ☐ Yes ☐ No

Patient Information:

Last Name:		First Name:	
Phone #: Cell:		Preferred days/times to call:	
Home:			
Email Address:		Mailing Address:	

Please answer the following questions.

1. Are you of Chinese descent? <input type="checkbox"/> Yes <input type="checkbox"/> No [If No, not eligible]
2. Have you ever been told you are H. pylori positive by a doctor? <input type="checkbox"/> Yes → When? _____ <input type="checkbox"/> No <input type="checkbox"/> Not sure
3. How old are you? _____ years [If <21, not eligible]
4. Are you planning to live in the New York City region for the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No [If No, not eligible]
5. In the past, have you had gastric surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure [If Yes, not eligible]
6. [Women only] Are you currently pregnant or breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A [If Yes, not eligible] For Men, Mark "N/A"
7. Are you interested in participating in up to 4 sessions on information and strategies for H. pylori medication adherence, side effects management and stomach cancer prevention? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
Notes: [If not interested in program, please indicate reason(s)]
8. Which languages/dialects are you comfortable speaking and reading in? Please list from most comfortable (#1) to least comfortable language. Speaking: 1. _____ Reading: 1. _____ 2. _____ 2. _____ 3. _____ 3. _____
9. During the last two weeks, have you taken any antibiotics or bismuth salts? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure [If Yes, not eligible]
10. A) Do you have the following symptoms: cough, shortness of breath, fever, chills, shaking chills, muscle pain, headache, sore throat, new loss of smell or taste? [If 2 or more symptoms, offer telephone study enrollment] B) Have you or anyone in your household tested positive for COVID-19 in the past 10 days? (If yes, offer telephone study enrollment)
11. (If screening by phone and participant is eligible, ask if interested in hearing more about the study. If not, end the screening. If interested, offer telephone or in-person enrollment and consent, based on participant's preference and safety. If an in-person enrollment and consent is feasible, notify the participant that he/she is required to follow NYUGSOM guidelines on personal protective equipment (ie. face masks) and social distancing during the meeting) What days and times are you available to speak more about the program? Please check the days/write in the times below.

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Day	<input type="checkbox"/> Sunday		<input type="checkbox"/> Monday		<input type="checkbox"/> Tuesday		<input type="checkbox"/> Wednesday		<input type="checkbox"/> Thursday		<input type="checkbox"/> Friday		<input type="checkbox"/> Saturday	
Time	From	To	From	To	From	To	From	To	From	To	From	To	From	To
	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	P	PM	PM

Notes: