

(For Pt. Nav. Use Only) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient ID \_\_\_\_\_ Eligible ☐ Not Eligible ☐  
Screening ☐ Diagnostic ☐ Treatment ☐  
Referral to Social Services ☐ Specify: \_\_\_\_\_  
Navigator \_\_\_\_\_

**Perlmutter  
Cancer Center**

**NYU Langone  
Health**

Event name: \_\_\_\_\_ Date: \_\_\_\_\_

## Stamp Out Cancer Brooklyn – Cancer Screening and Navigation Intake Form

**Eligibility (basic demographics, previous screenings and preventative services, personal/family history of cancer)**

Age \_\_\_\_\_ Zip Code of residence: \_\_\_\_\_ Preferred care area: ☐ Bkln ☐ Qns ☐ Manhattan ☐ LI ☐ SI

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Patient refused to report

### **Previous cancer screenings and history:**

**Have you done any of the following cancer screenings in the past year?**

☐ Breast ☐ Lung ☐ Cervical ☐ Colorectal ☐ Prostate ☐ Skin ☐ Other: \_\_\_\_\_

**Have you ever had any of the following vaccines?** ☐ Hepatitis A ☐ Hepatitis B ☐ HPV

**Have you ever been diagnosed with H. Pylori infection?** ☐ Yes ☐ No **When?** \_\_\_\_\_ **Treated?** ☐ Yes ☐ No

**Have you ever been diagnosed with any type of cancer?** ☐ Yes ☐ No **When** \_\_\_\_\_

**Type of cancer** \_\_\_\_\_ **Where were you treated?** \_\_\_\_\_

**Have you noticed any changes in your body over the past year?** ☐ Yes ☐ No

If yes, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a family member that has ever been diagnosed with cancer?** ☐ Yes ☐ No

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

**Are you interested in receiving assistance in completing screenings and preventative services?** ☐ Yes ☐ No

### **Health Screener:**

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

**Have you taken the COVID-19 vaccine?** ☐ Yes, Date: \_\_\_\_\_ ☐ No Name: \_\_\_\_\_ # doses: \_\_\_\_\_

**If applicable, are you taking any hormones?** ☐ Yes ☐ No **If yes, for how long?** \_\_\_\_\_  
Specify \_\_\_\_\_

**If applicable, have you had any gender-affirming surgeries?** ☐ Yes ☐ No

**If yes, specify** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Would you like to be contacted for participation in research studies and surveys?** ☐ Yes ☐ No

**Would you like to receive information about cancer prevention programs, services and research?** ☐ Yes ☐ No

**I have been provided information on the Stamp Out Cancer Brooklyn program navigation services and I consent to enroll:**

\_\_\_\_\_ (signature) \_\_\_\_\_/\_\_\_\_/\_\_\_\_ (date)

Last name: \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

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 May we leave a voice message? ☐ Yes ☐ No

Email Address: \_\_\_\_\_

Best Time(s) to Call: \_\_\_\_\_ Best Day(s) to Call: \_\_\_\_\_

Emergency Contact and relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Country of Birth \_\_\_\_\_ Preferred Language \_\_\_\_\_

PCP \_\_\_\_\_ Last visit \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

**What is your current gender identity?**

- ☐ Female ☐ Male ☐ Transgender Female/Male-to-Female ☐ Transgender Male/Female-to-Male ☐ Other  
☐ Choose not to disclose ☐ Genderqueer ☐ Gender Non-Binary/"X"

**How would you describe your emotional and physical attraction to others?**

- ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose ☐ Lesbian  
☐ Homosexual/Gay ☐ Heterosexual/Straight

**Which of the following categories best describes you?**

- ☐ White  
☐ Hispanic, Latino, or Spanish origin  
☐ Black  
☐ Middle Eastern or North African  
☐ Native Hawaiian or Pacific Islander  
☐ Asian  
☐ American Indian, Native, First Nations, Indigenous Peoples of the Americas, or Alaska Native  
☐ Some other Race or Origin (please specify): \_\_\_\_\_  
☐ Don't Know/Not Sure  
☐ Decline to state

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

- ☐ Never attended school or only kindergarten ☐ Some college  
☐ Grades 1-8 (Elementary) ☐ College graduate (4+ yrs.)  
☐ Grades 9-11 ☐ Post College  
☐ High school graduate or GED

Notes: \_\_\_\_\_

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