*** St. Vincent Cancer Care Mobile Mammography Program***

***8550 Naab Road #300***

***Indianapolis, In 46260***

Dear Participant:

The St. Vincent Cancer Care Mobile Mammography Program is pleased to partner with Butler University to offer you an on-site screening mammogram on the following date:

***Monday, October 26th : 8:30am – 3pm***

**Participation Information:**

* Review the screening guidelines to determine if you are eligible to participate.
* Complete the registration form.

Option 1 - You can complete the “paper-version” which is included in this document. Please remember to include the full name and contact number for your primary care physician, as well as, complete the highlighted preferred appointment section on page 1. Submit your completed registration form to St. Vincent Health/Michelle Mitchell by fax to (317) 583-2020.

Option 2 - You can also use our secured online system to submit your registration form. Please use the following link, <http://www.formstack.com/forms/?1644094-8FkYYuCw4s>.

(*Note: If you experience difficulty opening the link, please try using a different browser, such as Firefox or Chrome*.)

* Please anticipate receiving an email confirming the receipt of your registration information and your scheduled appointment time.
* Registration deadline – Your registration must be received by Friday, October 2nd, 2015.

**Appointment Information:**

* Screening appointments are typically 15-20 minutes. It is important for you to be on on-time for your appointment. If you are late, your mammogram time may be rescheduled.
* Please bring your insurance card(s) and driver’s license or photo ID with you to your mammogram appointment.
* Please wear a two piece outfit.
* You will be asked to wipe off your deodorant at the time of your mammogram. Fresh deodorant will be provided.
* If you have had a mammogram(s) completed in a facility out of state, please contact that facility to obtain past mammogram results and have that results sent to:

St. Vincent Breast Center

8550 Naab Road, Suite 300

Indianapolis, IN 46260

*Please request out of state results as soon as possible.*

**Information about receiving your screening results:**

* We will send the results from your mammogram to the primary care physician listed on your registration form. You **must** have a physician in order to be screened. A “physician” is defined as a primary care physician, nurse practitioner, OB/GYN, physician assistant, internal medicine physician, etc.
* We will also send a letter with your results to the address listed on your registration information. If additional tests are needed, the mobile mammography team will contact you within 2-4 working days to discuss what your next steps should be.

**Billing Information**

St. Vincent Health will submit the cost for your mammogram (including the CAD fee) to your health insurance provider for payment. If you have any questions regarding your health insurance coverage, please contact your health insurance provider.

Thank you for the opportunity to serve you!

Sincerely,

Michelle Mitchell, MSW, MEd

Mmitc013@stvincent.org

(317) 338-5434

**St. Vincent Cancer Care’s**

**Mobile Mammography Program**

**Screening Guidelines**

**~1. You must be 40 years of age or older**

~OR~

~If you are between the ages of 35-39, and have a history of breast cancer in your immediate family, then you are eligible for a screening mammogram.

**A doctor’s referral/order is required at the time of your screening.**

**~2. You must have a current primary care physician.**

Your physician’s information is mandatory at the time of your registration.

*Please call the St. Vincent CARE Line at (317)338-2273 for help in obtaining a local physician*.

**~3. Screening mammograms are annual exams.**

There must be at least 11 months in between the date of your last screening mammogram and a new mammogram appointment.

**Additional information**

If you are a woman with fibrocystic breasts, you are eligible for a screening mammogram

*If you have breast implants, please indicate this on your registration form under the surgical history section.*

If you are a previous Breast Cancer Patient, who has had a Mastectomy or Lumpectomy, you must be five or more years-out from your diagnosis in order to be screened on the mobile unit. A doctor’s order is required at the time of your screening. Please list the year of your diagnosis under the ‘surgeries section’ on your registration/history form.

Screening Mammograms are intended for women without symptoms of breast disease. If you have any of the following symptoms, you are **not eligible** for a screening mammogram and should follow-up with your primary care physician immediately:

Symptoms of Breast Disease\*

* Lump (or thickening) in a breast (with or without implants) or in an underarm area
* Dimpling or puckering of the skin anywhere on the breast
* Change in color (redness) or texture of the skin on the breast
* Retraction (sinking in) of the nipple
* Discharge or bleeding from the nipple
* Increase in size of one breast; change in shape or contour of the breast
* Changes in or around the nipple (i.e., dry, itchy or flaky skin; sores on the breast)
* Swelling in the breast or upper arm area

**Additional women who ARE NOT eligible for a screening mammogram:**

* Women who have had a Mastectomy or Lumpectomy for breast cancer and are less than 5 years from the original diagnosis.
* Pregnant women
* Nursing Mothers (Breastfeeding must have stopped completely at least 3 months prior to the screening.)
* Women who have had a follow-up recommendation after a previous mammogram, but never completed the follow-up recommendation
* Women who have had their last screening mammogram less than 11 months ago
* Women between the ages of 35-39 with no history of breast cancer in their immediate family and no referral/order from a primary care physician.
* Women under the age of 30



**MOBILE SCREENING SERVICES REGISTRATION / HISTORY FORM - Page 1 of 4**

Please complete and return this form to Michelle Mitchell, via fax to (317)583-2020,

**Butler University - Registration deadline** **– Friday, October 2nd, 2015**

***Butler University***

Monday, October 26th

8:30am – 3pm

Please list three preferred appointment times.

|  |
| --- |
| TIME |
|  |
|  |
|  |

Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous/maiden name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County you live in:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (Circle One): Single, Married, Divorced, Widowed, Separated Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race (Circle One): African American, Asian, Caucasian (white), Hispanic, Other \_\_\_\_\_\_\_\_\_\_\_, Refused to answer

\*\*HIPAA-May we leave a message at your home or work pertaining to this appointment with the mobile van

for gathering pertinent information if needed? (Please Circle One) YES NO

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

 *(Note: Your email address will only be used to confirm the receipt of your registration form and appointment time.)*

**EMPLOYER INFORMATION**

Are you employed? Please (circle one): Full-time / Part-time / Retired / Not Employed

Name of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE INFORMATION NEEDED**

## Please complete the information below exactly as it appears on your insurance card and

## remember to bring your insurance card(s) and driver’s license / photo ID with you to your screening appointment.

Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Policy Holder’s Employer’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_ Work Phone #(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Acct #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payor # (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please circle one) HRA, HAS, HMO, PPO, POS, EPO, NAP or CHOICECARE

Address for claims\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_

Phone Number of Customer Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your insurance need to be pre-certified? (Please circle) Yes No Pre-certified phone # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Status (Circle One): Full Time / Part Time / Retired Sagamore Route#: SAG\_\_\_\_\_\_\_\_ PLUS, SELECT OR DELEGATED

## SECONDARY INSURANCE INFORMATION - IF APPLICABLE

## Please complete the information below exactly as it appears on your insurance card and

## remember to bring your insurance card(s) and driver’s license / photo ID with you to your screening appointment.

Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Policy Holder’s Employer’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_ Work Phone #(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Acct #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payor # (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please circle one) HRA, HAS, HMO, PPO, POS, EPO, NAP or CHOICECARE

Address for claims\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_

Phone Number of Customer Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your insurance need to be pre-certified? (Please circle) Yes No Pre-certified phone # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Status (Circle One): Full Time / Part Time / Retired Sagamore Route#: SAG\_\_\_\_\_\_\_\_ PLUS, SELECT OR DELEGATED

**PAYMENT INFORMATION - SELF-PAY- P01**

**YES! Please bill me for the cost of my mammogram.**

## By marking the box above, you are indicating that you will pay for the cost of your screening mammogram and we will not file a claim with your health insurance provider. Please anticipate receiving a bill from St. Vincent Hospital and a separate bill from Northwest Radiology. Payment is not due at the time of your appointment. We cannot accept payments on the mobile unit.



**MOBILE SCREENING SERVICES REGISTRATION / HISTORY FORM - Page 2 of 4**

Please complete and return this form to Michelle Mitchell, via fax to (317)583-2020,

**Butler University - Registration deadline** **– Friday, October 2nd, 2015**

***Butler University***

Monday, October 26th

8:30am – 3pm

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_

## EMERGENCY CONTACT INFORMATION

## Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## MEDICAL INFORMATION

Have you had an unexplained cough for greater than three weeks? (Circle One) YES NO

## PHYSICIAN INFORMATION

## You must have the complete name and mailing address of your physician in order to have a mammogram.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please indicate if the person receiving your report is a PA or NP and not a physician. Circle the correct answer: Physician / Nurse Practitioner (NP) / Physician’s Assistant (PA)*

Complete Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the Dr’s specialty: D.O. / Family Practitioner / General Medicine / Internal Medicine / OB/GY / Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please complete the section below if you would like your screening results sent to an additional physician.*

# Physician/PA/NP Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Complete Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please circle the Dr’s specialty: D.O. / Family Practitioner / General Medicine / Internal Medicine / OB/GY / Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*If you are 65 or older AND/OR on Medicare PLEASE answer the questions that follow\*.**

*We are required by Medicare to obtain your retirement date and/or your spouse’s retirement date.*

**If you are not retired and not on Medicare, please skip the section below and complete the breast history section (page 3).**

|  |  |  |
| --- | --- | --- |
| Are you retired?  | YES | NO |
| Your exact retirement date would be?  |
| If you don’t know did you retire prior to the effective date on your Medicare Card?  | YES | NO |
| If it was prior to the effective date what is the effective date? |
| If no, was it more than 5 years ago?  | YES | NO |
| Is your spouse retired?  | YES | NO |
| What is your spouse’s exact retirement date? |
| If you don’t know was it prior to the effective date on the spouse’s Medicare card?  | YES | NO |
| If it was prior to the effective date, what is the effective date? |
| If no, was it more than 5 years ago?  | YES | NO |
| Should this be covered by a Workers’ Compensation claim? | YES | NO |
| Are you covered by the Black Lung Program? | YES | NO |
| Are you entitled to benefits through the Department of Veterans Affairs?  | YES | NO |
| Are these services covered by a Public Health Service other than Medicare or Medicaid?  | YES | NO |
| Are these services the result of an accident?  | YES | NO |
| Are you covered by an Employer Group Health Plan including Federal Employee Health Benefits or any retirement policy? | YES | NO |
| Have you been an in-patient of any hospital in the last 60 days | YES | NO |



**MOBILE SCREENING SERVICES REGISTRATION / HISTORY FORM - Page 3 of 4**

Please complete and return this form to Michelle Mitchell, via fax to (317)583-2020,

**Butler University - Registration deadline** **– Friday, October 2nd, 2015**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam\_\_\_\_\_\_\_\_\_\_\_\_\_**

PLEASE ANSWER ALL OF THE FOLLOWING AS COMPLETELY AS POSSIBLE:

***Place an X beside any new symptoms you are experiencing and duration of each. Circle RT or LT Breast:***

\_\_\_\_\_No Symptoms

\_\_\_\_\_Lump in breast Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RT LT First Noticed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Inverted nipple (sinking in) RT LT

\_\_\_\_\_Pain or tenderness in the breast RT LT \_\_\_\_\_Dimpling in skin of breast RT LT

\_\_\_\_\_Discharge from nipple RT LT \_\_\_\_\_Redness/swelling of breast RT LT

\_\_\_\_\_Other symptoms\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of last examination by a physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2. Have you had a previous mammogram (including mobile)? \_\_\_\_\_Yes \_\_\_\_\_No

3. When and where was your previous mammogram completed? Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name and Address of facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PLEASE PLACE AN X BESIDE ANY SURGERIES YOU HAVE HAD AND CIRCLE RT OR LT BREAST***

\_\_\_\_\_Lumpectomy (**Cancer)** Year\_\_\_\_\_RT LT \_\_\_\_\_Mastectomy Year\_\_\_\_\_RT LT

\_\_\_\_\_Biopsy (**Benign**) Year\_\_\_­­\_\_RT LT \_\_\_\_\_Cyst Aspiration Year\_\_\_\_\_RT LT

\_\_\_\_\_Breast Reduction Year\_\_\_\_\_RT LT \_\_\_\_\_Breast Implants Year\_\_\_\_\_RT LT

\_\_\_\_\_Tissue Donation Year\_\_\_\_\_RT LT Type of Implants\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Is there any possibility you are pregnant at this time?

YES NO Do you use an insulin pump?

YES NO Do you still have menstrual periods? Age began\_\_\_\_\_\_\_\_Date of last period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Have you had a hysterectomy? Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Have you had your ovaries removed? RT Year\_\_\_\_\_\_\_\_\_\_\_ LT Year\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Have you taken hormone replacements? What year to what year?\_\_\_\_\_\_\_\_\_\_\_\_Type\_\_\_\_\_\_\_\_\_\_\_

YES NO Have you taken birth control pills? What year to what year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Have you ever had a child? Number of pregnancies\_\_\_\_\_ Number of live births\_\_\_\_\_

Age at first live birth\_\_\_\_\_\_

YES NO Did you breast feed?

YES NO Have you ever had chemotherapy? Breast/Other Area of Body **(Please circle one)** Year\_\_\_\_\_\_\_\_

YES NO Have you ever had radiation to your breast? Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Prior radiation treatment to the chest (between the ages of 10 -30)

YES NO Are you of Ashkenazi Jewish Heritage?

YES NO Have you been BRCA tested? If yes, were results \_\_\_\_\_positive\_\_\_\_\_negative

YES NO Has a family member been BRCA tested? If yes\_\_\_\_\_positive\_\_\_\_\_negative\_\_\_\_\_unknown

 If yes, who was tested\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Has any relative been diagnosed with: Unknown/Adopted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Breast cancer Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ovarian cancer Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Endometrial cancer Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Uterine cancer Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Gynecologic cancer unspecified Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Colon cancer Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pancreatic cancer Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**MOBILE SCREENING SERVICES REGISTRATION / HISTORY FORM - Page 4 of 4**

Please complete and return this form to Michelle Mitchell, via fax to (317)583-2020,

**Butler University - Registration deadline** **– Friday, October 2nd, 2015**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam\_\_\_\_\_\_\_\_\_\_\_\_\_**

YES NO Have you been diagnosed with:

 Breast cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Ovarian cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Endometrial cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Uterine cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Cervical cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Gynecologic cancer, unspecified Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Colon cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Lung cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Lymphoma Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Melanoma Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

 Pancreatic cancer Age diagnosed\_\_\_\_\_\_\_\_\_\_ RT or LT

*To be completed by the mobile staff:*

Left

Right

 

COMMENTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Technologist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Msword/date/Breast Center Downtime History Sheet/July 2015