For office use only:

Date: _____

Location/County:_____

CHW: _____

Participant ID:_____

Kit Sticker:

Eligibility Questions:

Name (First Middle Last)			
Date of Birth	Age	Gender Identity:	Race you identify with: (circle all that apply) White Black Asian/Pacific Islander American Indian/Alaska Native Other:_____
Are you Hispanic or Latino? Yes No		Language Preferred: English Spanish Other: _____	Valid Texas Drive Yes
Mailing Address:		City/State/Zip	County of R
Email Address:		Phone Number:	Are you married with a partner? Yes
Emergency Contact:		Phone Number:	
What country were you born in? (circle one) United States Mexico Other: _____			How long have you been in the US?
Are you currently working? (circle one) Full time Part time Not Employed			
Highest Level of Education completed:	Do you have health insurance? Yes No	For someone your age, how would you rate your hea Excellent Very Good Good Fair Poor	
Household Income (circle the best answer): 1 - Less than $10,000 4- $20,000 - $25,000 7- $50,000 - $75,000		2 - $10,000 - $15,000 5- $25,000 - $35,000 8- $75,000 or more	3- $15,000 - $20,000 6- $35,000 - $50,000 Don't know Prefer not to ans

Intake Questions:

Do you have a regular doctor? Yes No	Doctor's Name and Clinic Address:

Do you drink alcohol? (circle one) Yes No	Do you use tobacco products? cigarettes/vape/chew/dip/hookah/etc. Yes No

Have you or anyone in your family been diagnosed with colon cancer? Yes

If you answered 'YES' to the previous question -- Circle all that apply and at what age?

Self	Mother	Father	Brother	Sister
Child	Aunt	Uncle	Grandmother	Grandfather
Cousin				

Over the last three months, have you noticed blood from your rectum or in your stool on more than one occasi
Yes No Don't know

Has a doctor ever recommended that you get tested for colorectal cancer? Yes

Has your doctor ever had you perform an at-home stool test? Yes

If 'Yes' -- When? _____

Have you ever had a colonoscopy? Yes No
If 'Yes': When? Month_____ Year_____
When did your doctor recommend that you have another colonoscopy? _____ years
Have you had your recommended follow-up colonoscopy? Yes
If 'Yes': When? Month_____ Year_____

Consent for Treatment:

I, _____, as a Get F.I.T. to Stay Fit program participant, hereby agree and acknowledge that I will receive mo cost colon cancer screening and diagnostic sercices only. I am aware and agree that, I will be responsible to pay for further office visits, office procedures, hospital and surgical fees and treatments or service(s) needed after final diagnosis is obtained.

I acknowledge that I am signing this statement voluntarily, and it is not being signed under duress or after services have already been provided. I understand that by signing this form, I will be fully responsible for my health care. I also understand that it is my choice to have any further services recommended by my healthcare provider and other healthcare access options provided by this organization.

Release of Medical Information:

I, _____, by signing this form, authorize you to release confidential health care information about me to Get FIT to Stay Fit. I also authorize Get FIT to Stay Fit to release confidential health care information about me to additional medical providers as needed concerning my diagnosis and treatment to continue my medical care.

Limitations on the information you may release subject to this Release Form are as follows:

_____
_____
_____

I have read this authorization or have had this authorization read to me. I understand and agree to its contents.

I have been informed that I may revoke this authorization by written statement at any time.

_____ _____
(Patient Signature or Legal Representative) (Date)

_____ _____
(Witness) (Date)

Texas Tech Physicians
SURGERY

CANCER PREVENTION & RESEARCH
INSTITUTE OF TEXAS

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