Sage Consent/Enrollment Form

Assign a new number for each visit

Sage Encounter Number

Version 1.0

You must read and sign this consent form if you want the Sage Program to pay for your cancer screening.

The Minnesota Department of Health (MDH) manages the Sage Scopes Colorectal Cancer Screening Program and the Sage Breast and Cervical Cancer Screening Program (collectively called "Sage Programs"). Sage Programs are funded by the Centers for Disease Control and Prevention (CDC) and the State of Minnesota.

Requirements to participate. You are not required by law to provide any information to the Sage Programs. However, if you do not provide the requested information, you may not be able to participate in the program. While MDH requests your Social Security number in order to better identify your records, you may participate in the program even if you choose not to provide your Social Security number.

Scope of Consent. This Consent Form allows the Sage Programs to:

- Obtain your medical information from your health care provider(s)
- Release your medical record information to CDC and its data contractor
- Assess cancer-screening services through the program
- Remind you of medically appropriate screening opportunities

I authorize doctors and other medical providers (including hospitals, clinics, and laboratories) to give the following information to the Sage Programs:

- All my identifying information, including my name, date of birth, address, phone numbers, health insurance, income, household size, race, ethnicity, place of birth, primary language, education, and Social Security number (if provided)
- Contact information for my doctors and health care providers, including their names, addresses, and telephone numbers
- Medical information collected during the program, including my chart number, weight, height, blood pressure, tobacco use, medical history, results of cancer screening tests, symptoms, follow-up tests, and treatment
- Cost data related to procedures covered by the Sage Program

The Minnesota Government Practices Act protects all information released to the Sage Programs. This means that the only people with access to my identifying information are my doctors, health care providers, and MDH employees who work with the Sage Programs or the Minnesota Cancer Surveillance System.

I authorize Sage Programs to share my information with doctors and health care providers involved in my medical care.

- Information released to doctors and health care providers is protected by federal or state medical privacy rules
- I authorize Sage Programs to share my medical information, cost data, and demographics with CDC and its data contractor
- Information released to CDC and its data contractor will not include my name, phone number, Social Security number, or address
- If I need coverage for treatment, I authorize Sage Programs to release this information to the Minnesota Department Human Services

Except for the release of information that I have authorized in this consent form, all information given to Sage Programs, CDC, and its data contractor will be kept confidential and will not be disclosed to others except as allowed or required by Minnesota or federal law.

Sage Programs will use my information to:

- Document my eligibility for the program
- Assure that I receive appropriate preparation, screening, and diagnostic follow-up
- Assist in locating resources to support treatment (if needed)
- Manage and evaluate the program
- Remind me of future screening opportunities

I may withdraw from Sage Programs and cancel the permissions authorized in this consent form. In order to cancel my permission I must send a letter to Sage Programs. The letter must include my name, date of birth, a statement canceling my permission to release information, and my signature. If I cancel my permission, I will no longer be enrolled in Sage Programs and may be financially responsible for any outstanding bills.

Patient Name: (printed)_____ Date of Birth:_____(mo.)_____(day)_____(yr.)

Patient Signature:_____ **Signature Date:**_____(mo.)_____(day)_____(yr.)

Note to health care providers: This document complies with the requirements of HIPAA (Health Insurance Portability and Accountability Act), the Federal Privacy Act of 1974, the Minnesota Government Data Practices Act, and the Minnesota Health Records Act, regarding authorizations to disclose protected health information. See C.F.R. § 164.508(c) (1); 5 U.S.C. 552a; Minn. Stat. §§ 13.05, subd. 4(d), 144.291 to 144.298.

SAGE MINNESOTA'S CANCER SCREENING PROGRAM

DEPARTMENT OF HEALTH

Personal Data: Please provide the following information

1. Name: _____
   Last First Middle Initial

2. Birthdate: ____/____/____ (Month / Day / Year)

3. Social Security #: ____-____-____

4. Street Address: _____

5. City: _____ 6. State: _____ 7. Zip: _____

8. County: _____ 9. Home phone: (___) _____ 10. Other phone: (___) _____

11. Are you Hispanic or Latina? (Mexican, South or Central American, Puerto Rican, Cuban, or other Spanish culture)

☐ Yes ☐ No

12. What race do you consider yourself? (Please check one or more of the following that identifies your race)

☐ White
☐ Black or African-American
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaskan Native
☐ Asian (specify) _____
(Hmong, Vietnamese, Korean, Cambodian, Chinese, Thai, Indian, or any other Asian)

☐ Other (specify) _____

13. In what country were you born? ☐ United States
☐ Other (specify) _____

14. What is the primary language spoken in your household? _____

15. Do you have **any** health insurance? (Including Medical Assistance, Medicare, Minnesota Care, or private insurance)

☐ Yes, _____
(If yes, write the name of the insurance)
☐ No

16. What is your total monthly household income before taxes? $_____ per month

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NOTE: If you farm or are self-employed, use net income (after deducting business expenses).

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17. Including yourself, how many people are supported by this income? (Check one box)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ 7 ☐ 8 ☐ 9 ☐ 10 or more

Go to next page ⇨

18. Have you ever had a mammogram? ☐ Yes ☐ No ☐ Don't know

19. Have you had a mammogram in the last year? ☐ Yes ☐ No ☐ Don't know

20. Have you ever had a Pap test? ☐ Yes ☐ No ☐ Don't know

21. Have you had a Pap test in the last 3 years? ☐ Yes ☐ No ☐ Don't know

22. Have you had a hysterectomy (removal of the womb or uterus)? ☐ Yes ☐ No ☐ Don't know
    If "Yes," was it done due to cervical cancer? ☐ Yes ☐ No ☐ Don't know

23. Have you ever had a colonoscopy (this is a test for colon and rectal cancer)? ☐ Yes ☐ No ☐ Don't know

24. Have you smoked cigarettes (tobacco) in the past… ☐ Week ☐ Month ☐ Year ☐ More than one year ago ☐ Never smoked

25. If you still smoke, would you like help quitting? ☐ Yes ☐ No

26. Does anyone else in your household smoke? ☐ Yes ☐ No

27. Please select your highest level of education:

- ☐ Grade 8 or less
- ☐ Grade 9-11 (some High School)
- ☐ Grade 12 or GED (HighSchool graduate)
- ☐ College or Technical School, but nodegree
- ☐ Associate degree (2-year college graduate)
- ☐ Bachelor's degree (4-year collegegraduate)
- ☐ Post-graduate degree (Master's Professional, or Doctorate)

Sage covers:

- ♦ A screening office visit **every year**
- ♦ A mammogram **every year** (a clinical breast exam isrecommended)
- ♦ Pap test **every 3 years or** Pap w/HPV co-testing every 5 years unless a prior Pap was abnormal
- ♦ Follow-up office visits and/or tests whenever there is an abnormal screening result

STOP - Provider to finish

Sage Encounter Number
Assign a new number for each visit

VISIT SUMMARY ☐ NEW Sage patient ☐ RETURNING Sage patient

Name_____ **Visit Date**____/____/____
Chart # _____

Patient's Height____ft.____in. **Weight**_____lbs. **Blood Pressure**____/____at today's visit

PATIENT HISTORY

Screening prior to this visit:	Yes ⇨ Record month/year of prior exam/test	*or*	Never had exam/test	*or*	Don't know if exam/test ever done
Clinical breast exam	☐ ⇨ ____/____mo/yr		☐		☐
Mammogram	☐ ⇨ ____/____mo/yr		☐		☐
Pap test	☐ ⇨ ____/____mo/yr		☐		☐

SAGE SERVICES PROVIDED THIS VISIT

Results Counseling only, to review prior Sage screening abnormality ☐ Breast abnormality ☐ Cervical abnormality

Does the patient report breast symptoms? (i.e. lump, bloody nipple discharge, dimpling, inflammation) ☐ Yes ☐ No

Does the patient report family history of breast cancer? (parent, sibling, child only) ☐ Yes ☐ No

Clinical Breast Exam (CBE) done at visit date listed above?

☐ Yes **If yes, CBE Findings** for this exam:

- ☐ **Normal CBE**, breast cancer not suspected.
- ☐ **Benign CBE**, breast cancer not suspected *(i.e., fibrocycstic changes, diffuse lumpiness, or modularity)*
- ☐ **CBE Suspicious for breast cancer,** diagnostic evaluation required, other than mammogram (i.e., discrete palpable mass, bloody/serous nipple discharge, nipple/areolar scaliness, skin dimpling/retraction). Suspicious CBE Description:_____

☐ No, CBE not done
☐ Patient refused CBE

Fine Needle Aspiration done at visit date listed above?

☐ No, not indicated
☐ Yes, cytology sent
☐ Yes, NO cytology sent

Breast Ultrasound ordered or done this visit?

☐ No, not indicated
☐ Yes
☐ Patient refused

Mammogram ordered or done this visit?

☐ Yes, routine screening
☐ Yes, to evaluate symptoms or prior abn
☐ No, not indicated
☐ Patient refused

Pap test done at visit date listed above?

☐ Yes, routine screening Pap
☐ Yes, surveillance Pap – prior abnormal
☐ No, not indicated
☐ No, pelvic exam only
☐ No, patient had a hysterectomy

Colposcopy done at visit date listed above?

☐ No, not indicated
☐ Yes, with Cervical Biopsy and ECS
☐ Yes, with Cervical Biopsy only
☐ Yes, with ECS only
☐ Yes, NO pathology sent

(ECS=Histological Endocervical Sampling)

Indication for Colposcopy this visit:

☐ ASC-US
☐ ASC-H
☐ LSIL
☐ HSIL
☐ Atypical Glandular Cells
☐ Surveillance Colp.

Abnormal Pap date____/____/____
Mo day yr

Other Cervical Services:

Endometrial Biopsy done at this visit for prior Sage Pap with Glandular or Endometrial Cell findings? ☐ Yes ☐ No

*Pap **not** covered in the instances listed below:*

Patient office visit to collect HPV Test for prior Sage conventional Pap with ASC-US result? ☐ Yes ☐ No

Patient office visit to collect HPV Test for 12 month follow-up after a colposcopy indicated by:

LSIL or ASC-H Pap (no CIN II or III on colp)? ☐ Yes ☐ No

ASC-US Pap (no CIN on colp and HPV+)? ☐ Yes ☐ No

Please complete and return to:

Minnesota Department of Health
Cancer Control Section
Sage Screening Program
P.O. Box 64882
St. Paul, MN 55164-0882