

**RECORD OF INFORMED CONSENT
TITLE XV BREAST AND CERVICAL CANCER
CONTROL PROGRAM**

The _____ Health Department is offering a Breast and Cervical Cancer Control Screening Program (BCCCP). This screening program is supported by the Federal Government as part of a national plan to reduce the number of women who die of breast or cervical cancer.

PURPOSE OF THIS PROGRAM

The purpose of the BCCCP is to find out if a woman has breast or cervical cancer and, if she has cancer, to refer her for treatment. Regular screening tests can help find a cancer that may be present when it is still very small. If cancer is found before it has spread to other parts of the body, chances of survival are better but not certain.

PURPOSE OF THIS FORM

- This form explains the BCCCP so that I can decide if I want to be in this program.
- This form is my invitation to be part of the screening program.

WHAT THE PROGRAM OFFERS

- This program offers the following screening services to eligible women:
 - Clinical breast exam every year
 - Mammogram every year
 - Pelvic exam every year
 - Pap test every one to three years, depending on history
- Cost of screening services:
 - Whether or not I have health insurance, I will not be charged for screening services provided by this program.
 - If I *do not* have insurance, I will receive the screening services at no cost.
 - If I *do* have insurance, I will receive the screening services at no cost. My insurance will be billed, but I will not have to pay any program charges as a result of the co-pay or deductible.

FOLLOW-UP OF ABNORMAL SCREENING RESULTS

- I will be informed of the results of these screening tests and of any additional follow-up that may be needed.
- It is my choice whether or not to follow the recommendations of the Health Department or my physician for follow-up of any tests that are abnormal.

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- If I have a personal physician, s/he will be informed of these results if I provide written approval to release this information.
- If any screening test shows something that is abnormal, the staff of the Health Department will help make plans for further exams to decide if there is a problem.
- The Health Department cannot pay for some diagnostic tests.
- Not all follow-up services are free; if I am unable to pay, the Health Department will help me find agencies and/or providers who will work with me to see that I receive needed services.

IF BREAST OR CERVICAL CANCER IS DIAGNOSED

- If breast or cervical cancer is diagnosed, the Health Department will refer me to my physician or to physicians who work with this program, to provide treatment for my cancer. I understand that the Health Department does not provide treatment.
- The Health Department does not pay for any treatment services for breast or cervical cancer.
- If I am unable to pay for treatment, the Health Department will work with me to assure that I receive appropriate services.

THINGS TO KNOW ABOUT SCREENING TESTS

RISKS:

- The risks associated with the screening tests are low.
- I may request and receive any information the Health Department has that helps explain the screening procedures and risks.
- I may ask questions at any time.

LIMITATIONS OF SCREENING TESTS

- No screening test is 100% accurate. Screening tests can sometimes miss an abnormality or show an abnormality when one is not present.
- Normal test results never rule out the later development of cancer. Repeat and regular screening is important.
- Having an abnormality does not always mean there is cancer. Only a few women with abnormal screening results will, after more tests, be diagnosed with breast or cervical cancer.

I AGREE TO:

- Be contacted when it is time to schedule the next screening appointment.
- Repeat these screening tests every year, or as recommended by my health care provider.

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- Be contacted if follow-up appointments are necessary.

I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll. The Health Department phone number is (____/____-_____)

Signature of Client

Date

Signature of Person Obtaining Informed Consent

Date

CONTENTS OF THIS FORM REMAIN IN EFFECT UNTIL NEXT ANNUAL VISIT.

Rev: 7/21/03