



Alaska Native Epidemiology Center
 Alaska Native Tribal Health Consortium
 4000 Ambassador Drive, D-CHS, Anchorage, Alaska 99508
 Phone: (907) 729-4567 Fax: (907) 729-4569



**ANTHC Colorectal
 Cancer Program**

*Funded by the
 Centers for Disease Control
 and Prevention*

ANTHC CRCCP Enrollment Form

Affix printed label here.

Client Information

Last Name:	Suffix: <i>(Sr., Jr.)</i>	First Name:	M.I.:	Maiden:
Date of Birth: <i>(mm/dd/yyyy)</i> / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	SSN: - -		
Street Address:			Apt/Unit #:	
City:		State:	Zip Code:	
Home Phone: () -	Work Phone: () -	Cell Phone: () -		
Are you of Hispanic origin? <input type="checkbox"/> No <input type="checkbox"/> Yes		Race <i>(check all that apply)</i> <input type="checkbox"/> Alaska Native <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> African American <input type="checkbox"/> Other		

*****ITEMS IN LIGHT GREY ARE OPTIONAL**

Insurance Information

Do you have the following: (select all that apply)

Medicaid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medicare	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IHS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Private Insurance *	<input type="checkbox"/> Yes	<input type="checkbox"/> No
*If you have private insurance, does it cover colonoscopy at 100%?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Learn of Program

How did you learn of this screening program? *(select all that apply)*

<input type="checkbox"/> Community Event	<input type="checkbox"/> Friend	<input type="checkbox"/> Radio Ad
<input type="checkbox"/> Family member	<input type="checkbox"/> Magazine	<input type="checkbox"/> TV Ad
<input type="checkbox"/> Doctor	<input type="checkbox"/> Mailing/Flyer	<input type="checkbox"/> Web site
<input type="checkbox"/> Other Health Care Provider	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Other _____

Eligibility

What is your total household income before taxes? \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Number of people in household? _____
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Medical History

Have you ever had any of the following colorectal screening tests: None _____

Test	Year	Result (check one)		
<input type="checkbox"/> Take home fecal test		<input type="checkbox"/> Normal/Negative	<input type="checkbox"/> Abnormal/Positive	<input type="checkbox"/> Don't know
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Normal	<input type="checkbox"/> Polyp(s)/Tumor(s)/Cancer	<input type="checkbox"/> Don't know
<input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Normal	<input type="checkbox"/> Polyp(s)/Tumor(s)/Cancer	<input type="checkbox"/> Don't know
<input type="checkbox"/> Barium enema (DCBE)		<input type="checkbox"/> Normal	<input type="checkbox"/> Polyp(s)/Tumor(s)/Cancer	<input type="checkbox"/> Don't know
<input type="checkbox"/> Other _____		<input type="checkbox"/> Normal	<input type="checkbox"/> Polyp(s)/Tumor(s)/Cancer	<input type="checkbox"/> Don't know

Have you ever been told by a health professional that you have had:

- Crohn's Disease Yes No Don't know
- Familial Adenomatous Polyposis (FAP) Yes No Don't know
- Hereditary Nonpolyposis Colorectal Cancer (HNPCC) Yes No Don't know
- Inflammatory Bowel Disease (IBD) Yes No Don't know
- Ulcerative Colitis Yes No Don't know

Have you ever been told you have/had colorectal cancer? Yes No Don't know

If yes, Date of diagnosis? (mm/dd/yyyy) ____/____/____

Have you ever been told you have/had polyps in your colon or rectum? Yes No Don't know

Were any of these precancerous polyps? Yes No Don't know

Do you have an immediate family member who has ever been diagnosed with colorectal cancer or precancerous polyps? (mother, father, sibling, child) Yes No Don't know

Have you been referred for colonoscopy because you are currently experiencing any of the following?*

- Rectal bleeding (in the past 6 months)? Yes No Don't know
- Blood in your stool (in the past 6 months)? Yes No Don't know
- Diarrhea (lasting more than 1-2 weeks)? Yes No Don't know
- Constipation (lasting more than 1-2 weeks)? Yes No Don't know
- Unexplained weight loss? Yes No Don't know
- Lower abdominal pain? Yes No Don't know

***If yes, please provide details:** _____

Program Use Only:

Indication for initial test: Screening Surveillance Diagnostic

Recommended Test:

FOBT FIT Sigmoidoscopy Colonoscopy Other _____

Date of appointment or FOBT/FIT kit distributed: (mm/dd/yyyy) ____/____/____

Adherence:

- Test pending Test performed (must complete an Intake Form)
- FOBT/FIT card not returned Appointment(s) not kept/Client no show

ANTHC Use Only:

Eligibility: Eligible Ineligible: (due to) Age Income Insurance Medical condition