Florida HEALTH
Putnam County

FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION SCREENING PROGRAM
PATIENT ENROLLMENT/REFERRAL FORM (PRF)

The Florida Department of Health in Putnam County invites you to take part in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). If you qualify, you may receive your breast and cervical cancer examinations free. If your test results are not normal, FBCCEDP will work with your doctors to help you obtain additional tests and, if needed, treatment.

There may be some cost to you for some tests if you have abnormal results and need diagnostics or treatment.

Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties

IDENTIFICATION/GENERAL INFORMATION **All fields must be completed for application to be processed.**

NAME: _____
Last First MI

Mailing ADDRESS: _____
Street Street City Zip County

Street ADDRESS: _____
Street City ZIP County

PHONE: _(_____)_____ Other Contact Phone _____

SSN: _____-_____-_____ **Date of Birth:** _____/_____/_____ **AGE:** _____

Tobacco Use 1) ☐ Daily 2) ☐ Some Days 3) ☐ Not at all 4) ☐ Declined to answer

We offer a free smoking cessation program. Would you be interested in entering our smoking cessation program?
☐ Yes ☐ No

BREAST EXAM BACKGOUND (Check only one box for each category)
Have you yourself ever been diagnosed with BREAST CANCER? ____ YES (year_____) ____ NO Implants: Yes/No? How long? _____
Family Hx: Yes/No? Circle: Grandma/Grandpa Mother/Father/Aunt/Sister/Brother?
When was your last MAMMOGRAM: (month_____ /year_____) ___ NONE ____Unsure (5+ years?)
Where was it done? (PROVIDER) _____

Height _____ Weight _____ BP _____ Hx of Hypertension / High Blood Pressure? Yes / No?

Diabetes? Yes / No? Type: _____

CERVICAL EXAM BACKGROUND
Have you yourself ever been diagnosed with invasive cervical CANCER? __ YES (year_____) __ NO
When was your last PAP SMEAR exam (month_____ /year_____) ____ NONE ____Unsure (5+ years?)

HYSTERECTOMY Yes/No (Partial/full) When? _____ **Cervix** Yes/No?

PROGRAM DATA: RACE – Check or circle ALL that apply:

__ AMERICAN INDIAN or ALASKAN NATIVE __ ASIAN __ BLACK/AFRICAN AMERICAN

__NATIVE HAWAIIAN or Other PACIFIC ISLANDER __ WHITE ___OTHER (PLEASE DEFINE) _____

PRIMARY LANGUAGE: ENGLISH / SPANISH **ETHNICITIY:** HISPANIC OR LATINO? YES / NO

DH 3203, 01/12
VOUCHER ISSUED: _____

Florida HEALTH
Putnam County

INCOME/INSURANCE INFORMATION: *(Required information. Please check or circle all that apply.)*

Check if you are receiving any of the following:
Medicare A Yes/No Medicare B Yes/No Medicaid Yes/No
Do you have any health insurance? YES____ Type_____ NO____

Number in Household_____
Monthly Income_____
Annual Income_____
Unemployment_____

Client Agreement

- I understand that no test is 100% accurate.
- This statement is true at the time it is made. I understand that the provider shall attempt to verify the statement. Verification can be secured by telephone, in written form, or by face-to-face contact; verification does not require a written document to confirm an applicant or client's statement. If the provider is unable to verify wages paid or an employer will not verify wages paid, the signed self-declaration statement provided by the applicant must be accepted as accurate.
- I have read or had the above read to me. I agree that the information I have provided is correct.

Client Signature: _____ Date: _____

Please Print Name: _____

Referred By: _____

PLEASE ATTACH ANNUAL APPLICATION AGREEMENT FORM SIGNED AND DATED. THANK YOU!

DH 3203, 01/12
VOUCHER ISSUED: _____