PUBLIC HEALTH DIVISION
ScreenWise Program

ScreenWise Program
Patient Intake Packet

Oregon Health Authority

Enrolling agency: _____ Site name: _____

Medical record number: _____ Date of enrollment: _____

Patient full name:	
Date of birth: Sex: ☐ Female ☐ Male ☐ Other	☐ Homeless or unstable housing? (*If so, check box and only write ZIP code and county below*)
Home address: Apartment number:	
City: State:	ZIP:
Phone:	County:

Do you have health insurance or Medicaid?:	☐ Yes ☐ Yes, but not enough to cover my needs ☐ No
What is your **gross monthly household income?** (*This is the total income before taxes for all household members)*:	$_____ monthly
How many people live in your household (*including yourself*)?:	_____ people

Hispanic or Latino origin?:	☐ Yes ☐ No ☐ Don't know/not sure ☐ Don't want to answer
Race (*check one or more*):	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Don't know/not sure ☐ Don't want to answer
In what language do you prefer to read?	☐ English ☐ Spanish ☐ Other:

*** Submit all intake packet information to ScreenWise within 5 business days**

Patient consent

The Oregon ScreenWise program (*ScreenWise*), a program of the Oregon Health Authority, aims to reduce breast and cervical cancer, by promoting prevention and early detection.

ScreenWise may pay for:

- Screening and diagnostics for breast or cervical cancer
- Screening for hereditary cancer using genetic counseling and testing for BRCA 1 and 2 to identify high-risk patients
- Patient navigation and support

ScreenWise will not pay for breast or cervical cancer treatment. If treatment is needed, patients may apply for the Medicaid Breast and Cervical Cancer Treatment Program (BCCTP).

By signing this form, I understand that:

- My enrollment may start up to three months before the date signed below, allowing ScreenWise to pay for eligible claims during that period.
- I will remain enrolled in ScreenWise for one year while I am still eligible and do not ask to be taken out of the program.
- My provider will assess my eligibility to remain in the program every year.
- ScreenWise, my medical care providers, clinics and/or hospitals may share information with one another about my health care and any related medical care I receive through ScreenWise; and may organize my care and involvement in appropriate screening and/or diagnostic services, genetic counseling, and testing related to breast and cervical cancer.
- My information will not be shared with anyone outside of the Oregon Health Authority, its contracted providers and funders; and any published report will not use my name.
- I may receive written, telephone or electronic communications related to ScreenWise services.
- My provider must tell me in writing about any services that are not covered by ScreenWise.

By signing this form, I confirm that:

I meet all of the following eligibility requirements for the program:

- ✓ I live in or intend to live in Oregon
- ✓ My household income is at or below 250% of the Federal Poverty Level
- ✓ I do not have insurance or my insurance does not fully cover my needs

Patient signature: Date:

Patient name (*printed*):

You can get this document in other languages, large print, braille or a format you prefer. Contact Screenwise at 971-673-0581. We accept all relay calls or you can dial 711.

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Patient service eligibility	
Does the patient need breast or cervical cancer diagnostic services?	☐ 21-49 years old* *Patients 21-49 are not eligible for enrollment unless diagnostic services are needed ☐ 50 years or older
Breast cancer assessment **selections do not affect eligibility**	
Ashkenazi Jewish origin?	☐ Yes ☐ No ☐ Unknown ☐ Refused
Has patient, or any of their close blood related relatives ever been diagnosed with breast, fallopian tube, male breast, melanoma, ovarian, pancreatic, peritoneal, or prostate cancers?	☐ Yes ☐ No ☐ Unknown ☐ Refused
Breast cancer risk?	☐ Yes ☐ No ☐ Unknown
Breast cancer services	
CBE date: _____ (MM/YYYY)	☐ Normal exam/benign finding ☐ Abnormal/suspicious for cancer ☐ Not performed
Mammogram ordered?	☐ Yes ☐ No ☐ Sent directly for diagnostics (*e.g. ultrasound, etc*.)
Cervical cancer assessment **selections do not affect eligibility**	
Previous pap?	☐ Yes, date (*if known*): _____ (MM/YYYY) ☐ No ☐ Unknown
Cervical cancer risk?	☐ Yes ☐ No ☐ Unknown
Cervical cancer screening services	
Pap date: _____ (MM/YYYY)	☐ Routine screening ☐ Surveillance ☐ Pap elsewhere, referred in for diagnostics ☐ Pap after primary HPV+ ☐ No pap done ☐ No cervical services performed
HPV ordered?	☐ Yes ☐ No