**FITWAY Patient Eligibility / Risk Assessment/ Screening Form** **Tracking #:** | | | | | | | | | | | | |

**Medical Record #:**________________ **Date of Birth**: _____/_____/_____ Gender: ___ M ___ F **Today's date:**_____________________

**Name**: ________________________________________________________________________ **SS #:** _______/______/__________
*First* *Middle Initial* *Last*

**Address**: ______________________________________________________________ **Residence County**: ______________________________

______________________________________________________________________ **Telephone #:** (________) __________________________
*City/ Town* *State* *Zip Code*

**Ethnicity**: ___Hispanic ___non-Hispanic **Race**: (***Check all that apply)*** ___ White ___ Black ___ Asian ___ Native Hawaiian or Other Pacific Islander ___American Indian or Alaska Native ___Unknown

**Do you use Tobacco Products? YES ____ (Refer to Tobacco Cessation Hotline: 1-800- 784-8669)**

**Patient Medical History:** **Patients answering YES to ques. 1-4 are NOT ELIGIBLE for enrollment into the FITWAY Program**

1) Have you ever been diagnosed with colorectal cancer or pre-cancerous polyps? ___**YES** ___No ___Unknown

2) Has your mother, father, brother(s), sister(s) or child ever been diagnosed with colorectal cancer? ___**YES** ___No ___Unknown

3) Have you ever been diagnosed with inflammatory bowel disease (ulcerative colitis or Crohn's Disease), FAP, or Lynch Syndrome/ HNPCC? ____**YES** ___No ___Unknown

4) Are you currently having any of the following symptoms?

**____Unexplained, significant weight loss (10% or more of regular body weight)**

**____Consistently narrow stools (example: the size of a pencil)**

**____Blood mixed throughout the stool (more than slight bleeding seen on tissue or in the toilet bowl)**

**NOTE: If a patient is currently experiencing a hemorrhoidal flare-up, they ARE ELIGIBLE for enrollment in the Program; however, the patient should wait until the flare-up is over before completing their FIT.**

**5. Have you ever had a colorectal screening test?** ___ Yes ___No **If Yes, which test?** ___Take-home FIT ___Take-home FOBT ___Sigmoidoscopy ___Colonoscopy ___DCBE ___CT colonoscopy ___Stool DNA

**6. Screening Provider's Name**: ____________________________________________

**Provider Specialty:** ___General Practitioner ___Internist ___Family Practitioner ___Gastroenterologist ___General Surgeon ___Colorectal Surgeon ___LPN ___RN ___Nurse Practitioner ___Physician Assistant ___OB/GYN ___CHD ___Radiologist

**7. Date FIT given to Patient**: ____/____/_____ (*MM/ DD/ YYYY*) **8. Indication for FIT: ______ Screening**

**9. Date FIT returned:** ____/____/_____ (*MM/ DD/ YYYY*)

**10. Date FIT tested:** ____/____/_______ (*MM/ DD/ YYYY*)

**11. Result of FIT cards** **(the more severe of the two***)*

**___FIT Negative** (no further testing needed in this Cycle)

**___FIT Positive** **Patient must be referred for diagnostic colonoscopy**

**___FIT pending/unsatisfactory result**

**12. Screening Adherence:**

**___FIT returned and tested** **___FIT pending**

**___FIT not returned** **___Appt. not kept**

**Documented Follow-up for Unreturned FITS:**

**______Phone call Date:** _____/______/______
**______Postcard Date:** _____/______/______
**______Letter Date:** _____/______/______

**Diagnostic Provider Name:** ____________________________________________

**Diagnostic Provider Telephone:** (________) _______________________________

**Date of Diagnostic Colonoscopy:** ____/_____/______ (*MM/ DD/ YYYY*)