

Registration & Consent Form

IMPORTANT - Please read the instructions below. Please bring a completed copy of this form with you to your screening appointment.

Use BLOCK LETTERS or and sign. Please check the pre-filled information and update as required. For Example: Yes No

Your personal information is protected by law including the *Health Records Act 2001 (Vic)*. We must collect information under the Improving Cancer Outcomes Act 2014 to provide breast cancer screening and assessment. Your information may be used for the purpose of funding, planning and monitoring our program and conducting training and research into breast cancer and breast screening. Read our Privacy Policy online at breastscreen.org.au/privacy

The details provided below may be used to contact you and leave a message identifying ourselves as BreastScreen Victoria

<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	<input type="checkbox"/> Other _____	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
					D	D	M	M	Y	Y	Y	Y
Family name _____				Mobile	_____							
Given names _____				Home	_____							
Family name at birth _____				Work	_____							
Email _____												
Home address _____												
Postal address _____												

Q1 Country of birth

Q2 Do you speak a language other than English at home? Yes No (If No, go to Q3)

If **Yes**, what is the main language you speak at home?

Q3 Are you of Aboriginal or Torres Strait Islander origin? Yes No (If No, go to Q4)

If **Yes**, are you Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

Q4 The results from your breast screen will be sent to you. If you would also like a copy sent to your doctor(s) or breast specialist please provide their details below.

Doctor _____	Doctor _____
Clinic name _____	Clinic name _____
_____	_____
Address _____	Address _____
_____	_____
_____ Postcode _____	_____ Postcode _____
Phone number _____	Phone number _____

BreastScreen Victoria does not screen women who are pregnant or breastfeeding.

We recommend you wait until three months after you stop breastfeeding to have a breast screen.

Q5 Are you, or could you be, pregnant? Yes No

Q6 Are you breastfeeding? Yes No

Q7 Are you currently using Hormone Replacement Therapy (HRT)? Yes No (If No, go to Q8)

If **Yes**, did you start using HRT after your last breast mammogram? Yes No

Q8 Was your last mammogram outside of the BreastScreen Victoria program? Yes No (If No, go to Q9)

If **Yes**, please give location and date (month & year), an estimate is fine.

Location Date

Q9 Have any of your family members (blood relatives) ever been diagnosed with BREAST cancer?

Only Include; **Mother, father, sister, brother, daughter, son, aunt, uncle, half-sister, half-brother, grandmother, grandfather, niece** or **nephew.**

Yes **No** **Do not know**

If **Yes**, please complete the following table:

Family member (For example MOTHER)	Age cancer found (If uncertain, please estimate)	Where breast cancer found			Side of family	
		One breast	Both	Unknown	Mother's side	Father's side
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Questions 10 and 11 refer ONLY to ovarian cancer; NOT other abdominal, cervical or uterine cancer.

Q10 Have any of your blood relatives ever been diagnosed with ovarian cancer? **Yes** **No** **Do not know**

Only Include; **Mother, sister, daughter, aunt, half-sister, grandmother** or **niece.**

If **Yes**, please complete the following table:

Family member	Mother's side	Father's side
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

Q11 Have you had ovarian cancer in the past? **Yes** **No**

Q12 Have you had breast cancer or DCIS (pre-cancer) in the past? **Yes** **No** (If No, go to Q13)

If **Yes**, was your breast treated by

Breast-conserving surgery (removal of lump)

Mastectomy (removal of breast)

Other, please specify _____

Which breast(s)? Right Left

Which year were you diagnosed?

Y Y Y Y

Q13 Have you previously had surgery to either breast (excluding breast implants)? **Yes** **No** **Right** **Left**

If **Yes**, In the past two years More than two years ago If more than two years, approximately what year?

Y Y Y Y

BreastScreen is a program for well women with NO breast symptoms. If you have a symptom please see your doctor BEFORE attending BreastScreen.

Q14 Do you have breast lump(s) that you can feel NOW? **Yes** **No** (If No, go to Q15)

If **Yes**, which breast is the lump in?

Has the lump been present for less than 12 months?

Has your doctor examined the lump?

Right Left

Yes No

Yes No

Q15 Do you have a bloodstained or watery nipple discharge NOW? **Yes** **No** (If No, go to Q16)

If **Yes**, is the nipple discharge bloodstained or clear/watery?

Which breast has the nipple discharge?

Has the nipple discharge been present for less than 12 months?

Has your doctor examined the nipple discharge?

Bloodstained Clear/watery

Right Left

Yes No

Yes No

Q16 Do you have any other breast symptoms NOW? **Yes** **No** **Right** **Left**

(If No, go to Q17) If **Yes**, please specify _____

Q17 Do you consent to BreastScreen Victoria obtaining or sharing your breast images and related files for the purpose of comparison and your care as described in the BreastScreen Victoria Information Sheet? **Yes** **No**

By signing below I acknowledge I have read and understand the *BreastScreen Victoria information sheet*.
I acknowledge that the information on this form is correct. I agree to participate in the BreastScreen program.
I understand that I can ask questions, stop the screening mammogram or withdraw from the program at any time.

Signature

Date / /

Name _____