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**

BreastScreen Victoria

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

☐ Mrs ☐ Miss ☐ Ms ☐ Other _____ Date of birth ☐☐/☐☐/☐☐☐☐ (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 _____

Clinic name _____

Address _____

_____ Postcode _____

Phone number _____

Doctor _____

Clinic name _____

Address _____

_____ Postcode _____

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 ☐☐/☐☐☐☐ (M M Y Y Y Y)

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: One breast	Both	Unknown	Side of family: Mother's side	Father's side
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

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
	☐	☐
	☐	☐

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? ☐ Right ☐ Left

Has the lump been present for less than 12 months? ☐ Yes ☐ No

Has your doctor examined the lump? ☐ 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? ☐ Bloodstained ☐ Clear/watery

Which breast has the nipple discharge? ☐ Right ☐ Left

Has the nipple discharge been present for less than 12 months? ☐ Yes ☐ No

Has your doctor examined the nipple discharge? ☐ 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 ☐☐/☐☐/☐☐☐☐ (D D / M M / Y Y Y Y)

Name