

**Patient Information and Enrollment Form**

**In order to receive a FIT Kit, you must:**

* Be a Wyoming resident; Age 45-75.
* Have not had colonoscopy in the last 10 years; had a stool test (FIT Kit/FOBT) in the last year; had a stool DNA test (FIT-DNA) in the last three years.
* Have no history of bleeding ulcers or hemorrhoids.
* Have no current symptoms, including bleeding or blood in the stool.
* Be a person of average risk.
* Have no personal history of colorectal cancer or adenomatous (pre-cancerous) polyps.
* Have no personal history of inflammatory bowel disease (ulcerative colitis or Crohn’s disease).
* Have no family history of colorectal cancer or polyps or a hereditary colorectal cancer syndrome such as familial adenomatous polyposis or Lynch syndrome (hereditary non-polyposis colon cancer).

**Facts about FIT Kits:**

* The kit works by detecting small amounts of blood in the stool.
* If done every year, they can help find polyps and cancer before they become a problem.
* They are done at home and tested by the PHN Office.
* If the FIT kit results are abnormal, you will likely need a colonoscopy.

**How do I use the FIT Kit?**

* Put the kit in the bathroom so it will be there when you need to use it.
* Follow the directions included with your kit.
* After you collect the sample, write the date the sample was collected on the collection vial baggy, place the sample and the bottom portion of this page in the envelope and return it to the clinic who provided you with the test.

The information provided below will be used by the <<CLINIC TO UPDATE WITH CONTACT NAME>> to process your kit and contact you with your results.  All screening information is kept confidential by the clinic staff. For questions, contact <<CLINIC CONTACT INFORMATION>>.



First Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year of Prior Screening (if known): \_\_\_\_\_\_\_\_\_\_ Insurance Type (circle): Private Medicaid Medicare Other

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*By accepting this FIT kit, you are acknowledging you will be able to complete and return the sample in the enclosed envelope within 30 days. There is no cost to you for completing the FIT kit. Test results will be provided via letter or telephone call.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_