For office use only:

Date: ______________________________

Location/County:____________________

CHW: _______________________________

Participant ID:______________________

Kit Sticker:

Eligibility Questions:

<table>
<tr><td colspan="6">Name (First Middle Last)</td></tr>
<tr><td>Date of Birth</td><td>Age</td><td>Gender Identity:</td><td colspan="3">Race you identify with: (check all that apply)
White Black Asian/Pacific Islander
American Indian/Alaska Native Other:___________</td></tr>
<tr><td colspan="2">Are you Hispanic or Latino?
Yes No</td><td colspan="3">Language Preferred:
English Spanish Other: ___________</td><td>Valid Texas Driver License:
Yes No</td></tr>
<tr><td colspan="3">Mailing Address:</td><td colspan="2">City/State/Zip</td><td>County of Residence:</td></tr>
<tr><td colspan="3">Email Address:</td><td colspan="2">Phone Number:</td><td>Are you married or living with a partner?
Yes No</td></tr>
<tr><td colspan="3">Emergency Contact:</td><td colspan="3">Phone Number:</td></tr>
<tr><td colspan="5">What country were you born in? (check box)
United States Mexico Other: _______________</td><td>How long have you been in the US?</td></tr>
<tr><td colspan="6">Are you currently working? (check box) Full time Part time Not Employed</td></tr>
<tr><td colspan="2">Highest Level of Education completed:</td><td>Do you have health insurance?
Yes No</td><td colspan="3">For someone your age, how would you rate your health?
Excellent Very Good
Good Fair Poor</td></tr>
<tr><td colspan="6">Household Income (check the best answer):
1 - Less than $10,000 2 - $10,000 - $15,000 3- $15,000 - $20,000
4- $20,000 - $25,000 5- $25,000 - $35,000 6- $35,000 - $50,000
7- $50,000 - $75,000 8- $75,000 or more Don't know Prefer not to answer</td></tr>
</table>

Intake Questions:

Do you have a regular doctor? Yes No	Doctor's Name and Clinic Address:

Do you drink alcohol? (check one) Yes No	Do you use tobacco products? cigarettes/vape/chew/dip/hookah/etc. Yes No

Have you or anyone in your family been diagnosed with colon cancer? Yes No

If you answered 'YES' to the previous question -- Check all that apply and at what age?

Self	Mother	Father	Brother	Sister
Child	Aunt	Uncle	Grandmother	Grandfather
Cousin				

Over the last three months, have you noticed blood from your rectum or in your stool on more than one occasion?
Yes No Don't know

Has a doctor ever recommended that you get tested for colorectal cancer? Yes No

Has your doctor ever had you perform an at-home stool test? Yes No

If 'Yes' -- When? ________________________________

Have you ever had a colonoscopy? Yes No

If 'Yes': When? Month_____________ Year_______________

When did your doctor recommend that you have another colonoscopy? ______________ years

Have you had your recommended follow-up colonoscopy? Yes No

If 'Yes': When? Month_____________ Year_______________

Would you like to enroll in our texts? Yes No

Comments:

Consent for Treatment:

I, ___________________________________, as a Get F.I.T. to Stay Fit program participant, hereby agree and acknowledge that I will receive no cost colon cancer screening and diagnostic sercices only. I am aware and agree that, I will be responsible to pay for further office visits, office procedures, hospital and surgical fees and treatments or service(s) needed after final diagnosis is obtained.

I acknowledge that I am signing this statement voluntarily, and it is not being signed under duress or after services have already been provided. I understand that by signing this form, I will be fully responsible for my health care. I also understand that it is my choice to have any further services recommended by my healthcare provider and other healthcare access options provided by this organization.

Release of Medical Information:

I, _________________________________, by signing this form, authorize you to release confidential health care information about me to Get FIT to Stay Fit. I also authorize Get FIT to Stay Fit to release confidential health care information about me to additional medical providers as needed concerning my diagnosis and treatment to continue my medical care.

Limitations on the information you may release subject to this Release Form are as follows:

____

____

____

I have read this authorization or have had this authorization read to me. I understand and agree to its contents.

I have been informed that I may revoke this authorization by written statement at any time.

____   _________________________

(Patient Signature or Legal Representative)   (Date)

____   _________________________

(Witness)   (Date)