Kit #______________________________

Consent for Fecal Occult Blood (iFOBT) Screening

Participant Information PRINT CLEARLY	Primary Care Provider (doctor, nurse practitioner etc.)
Name	Provider's Name
Date of Birth Age ☐Male ☐Female	Clinic
Address	Address
City, State, Zip	City, State, Zip
Telephone #	Telephone #

Race: (Optional, information will be used for demographic purposes.)
☐ Caucasian/white ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic ☐ Other

How did you hear about this event? ☐ Doctor/Provider ☐ Family/Friend ☐ Email/Newsletter ☐ Poster/Flier
☐Website ☐ Facebook/Blog ☐ Radio/News ☐ Other: ______________________________

Participant Information:

Please Check:	YES	NO
1. Have you ever been diagnosed with colorectal cancer?		
2. Have you ever had a colonoscopy? If yes, when?		
3. Do you have a reason to believe you are "high-risk" to get colorectal cancer? Why?		
4. Do you currently have medical insurance coverage?		

Consent for Screening:

- I hereby consent to do a fecal occult blood screening. I understand that this test checks stool samples for hidden blood which can be a sign of cancer, polyps or other internal disorders. A negative iFOBT screening result **does not assure the** absence of colorectal cancer. This test does not replace a colonoscopy which is the best method to detect colorectal cancer.
- I understand the benefits and alternatives involved with this screening method.
- I understand that the results of this fecal occult blood screening will not be part of my medical record.
- I hereby authorize Coborn Cancer Center to release my fecal occult blood screening results to me and if positive to my primary care provider (if identified above).
- For diagnosis of a medical problem, I understand I must see my primary care provider for a complete medical examination. It is my responsibility to contact my primary care provider regarding the results of this screening.
- I understand that I will receive a copy of this form.
- I understand the Coborn Cancer Center will compile information gained from this screening for statistical purposes and will maintain all information in accordance with state and federal confidentiality and/or privacy laws.

I HEREBY RELEASE COBORN CANCER CENTER AND CENTRACARE LABORATORY SERVICES FROM ALL RISKS ASSOCIATED WITH FECAL OCCULT BLOOD SCREENING, ACCIDENTS, INJURIES, ILLNESSES OR OTHER DAMAGE AND LOSSES OF ANY KIND, WHETHER FORSEEN OR UNFORSEEN, WHICH MAY ARISE DIRECTLY OR INDIRECTLY FROM MY PARTICIPATION IN THIS SCREENING PROGRAM.

I (Print Name) ____ have read this consent form and I understand and agree to its contents.

Participant Signature____________________________________ Date______________________