# Sage Consent/Enrollment Form

Sage Encounter Number
Assign a new number for each visit

___ ___

Version 4.0

The Minnesota Department of Health (MDH) manages the Sage Colorectal Cancer Program, the Sage Breast and Cervical Cancer Screening Program, and SagePlus (Well Integrated Screening and Evaluation for Women Across the Nation/"WISEWOMAN"). These programs are collectively called "Sage Programs" (we/us/our/Sage). Sage Programs are paid for by the Centers for Disease Control and Prevention (CDC) and the State of Minnesota.

**Please read and sign this consent form to receive program-covered services paid for by Sage Programs.**

**How to participate.** Sage Programs needs to collect some medical and personal information from you and your Sage providers. Federal and state laws protect the information that we collect, create, or maintain about you. All of your private information will be kept securely and we will not disclose it to others except as permitted by you in this form, or as allowed or required by law.

You are not required to provide any information to us, however, if you do not provide all of the requested information, you may not be able to receive certain services from Sage Programs.

**Sage Programs will use your information to:**

- Determine your eligibility for the program
- Assure that you receive appropriate preparation, screening, and diagnostic follow-up
- Help connect you to resources to support your treatment (if needed)
- Manage and evaluate the program
- Remind you about upcoming screenings and alert you to other program opportunities

**If you agree to sign up, you give permission for your Sage providers to give the following to Sage Programs:**

- Personal information, including your name, date of birth, address, and phone number
- Contact information for your doctors and other health care providers
- Medical information collected while participating in the program
- Cost data related to services covered by Sage Programs

**You also give Sage Programs permission to share information it has about you with your Sage providers.** If you need additional coverage for treatment, you also authorize Sage Programs to release this information to your state and county human services agencies.

**You may withdraw from Sage Programs and cancel the permissions given in this consent form at any time.** In order to cancel your permission, you must send a letter to Sage Programs. The letter must include the date, your name, date of birth, a statement canceling your permission to release your information, and your signature. **PLEASE NOTE: If you cancel your permission, you will no longer be enrolled in Sage Programs and may be financially responsible for any outstanding medical costs incurred while you were enrolled.**

**I choose to participate in the services offered by Sage Programs and agree to the conditions described above.**

Patient Name: (printed) ______________________________ Date of Birth: _________ (mo.) _________ (day) _________ (yr.)

**Patient Signature:** ______________________________ **Signature Date:** _________ (mo.) _________ (day) _________ (yr.)

**Note to health care providers:** This document complies with the requirements of HIPAA (Health Insurance Portability and Accountability Act), the Federal Privacy Act of 1974, the Minnesota Government Data Practices Act, and the Minnesota Health Records Act, regarding authorizations to disclose protected health information. See C.F.R. § 164.508(c) (1); 5 U.S.C. 552a; Minn. Stat. §§ 13.05, subd. 4(d), 144.291 to 144.298.

## Personal Data: Please provide the following information

1. Name: ______________________________________________
   Last     First     Middle Initial

2. Birthdate: ______/_______/______ (Month / Day / Year)

3. Social Security # (optional): _________-_______-____________

4. Street Address: ______________________________________________

5. City: ____________________

6. State: __________

7. Zip: ______________

8. County: ______________

9. Primary phone: (____) __________

10. Other phone: (_____) __________

11. Email address: ______________________________________________

12. Are you Hispanic or Latino? (Mexican, South or Central American, Puerto Rican, Cuban, or other Spanish culture) ☐ Yes ☐ No

13. What race do you consider yourself? (Please check one or more of the following that identifies your race)
    - ☐ White
    - ☐ Black or African-American
    - ☐ Native Hawaiian or other Pacific Islander
    - ☐ American Indian or Alaskan Native
    - ☐ Asian (specify) ______________________________
      (Hmong, Vietnamese, Korean, Cambodian, Chinese, Thai, Indian, or any other Asian)
    - ☐ Other (specify) ______________________________

14. In what country were you born?
    - ☐ United States
    - ☐ Other (specify) ______________________________

15. What is the primary language spoken in your household? ______________________

16. Please select your highest level of education:
    - ☐ Grade 8 or less
    - ☐ Grade 9-11 (some High School)
    - ☐ Grade 12 or GED (High School graduate)
    - ☐ College or Technical School, but no degree
    - ☐ Associate degree (2-year college graduate)
    - ☐ Bachelor's degree (4-year college graduate)
    - ☐ Post-graduate degree (Masters, Professional, or Doctorate)

17. Do you have **any** health insurance? (Including Medical Assistance, Medicare, Minnesota Care, or private insurance)
    - ☐ Yes, ______________________________
      (If yes, write the name of the insurance)
    - ☐ No

18. Including yourself, how many people live in your household? (Check one box)

    | | | | | |
    |---|---|---|---|---|
    | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
    | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 or more |

19. What is your total monthly household income before taxes? $______________ per month

**NOTE: If you farm or are self-employed, use net income (after deducting business expenses).**

Go to next page

| | | | |
|---|---|---|---|
| 20. Have you ever had a mammogram? | ☐ Yes | ☐ No | ☐ Don't know |
| 21. Have you had a mammogram in the last year? | ☐ Yes | ☐ No | ☐ Don't know |
| If "Yes," was it an abnormal result? | ☐ Yes | ☐ No | ☐ Don't know |
| 22. Have you ever had a Pap test? | ☐ Yes | ☐ No | ☐ Don't know |
| 23. Have you had a Pap test in the last 3 years? | ☐ Yes | ☐ No | ☐ Don't know |
| If "Yes," was it an abnormal result? | ☐ Yes | ☐ No | ☐ Don't know |
| 24. Have you had a hysterectomy (removal of the womb or uterus)? | ☐ Yes | ☐ No | ☐ Don't know |
| If "Yes," was it done due to cervical cancer? | ☐ Yes | ☐ No | ☐ Don't know |
| 25. Have you ever had a colonoscopy (this is a test for colon and rectal cancer | ☐ Yes | ☐ No | ☐ Don't know |
| If "Yes," have you had one in the last 10 years? | ☐ Yes | ☐ No | ☐ Don't know |
| 26. Do you smoke? | ☐ Yes | ☐ No | ☐ Don't know |
| 27. Have you smoked cigarettes (tobacco) in the past… | ☐ Week | ☐ Month | ☐ Never smoked |
| | ☐ More than one year ago | | |
| 28. If you smoke, would you like help quitting? | ☐ Yes | ☐ No | |
| 29. Do you live with someone who smokes? | ☐ Yes | ☐ No | ☐ Refused to answer |

Sage covers:

- A screening office visit **every year**
- A mammogram **every year** (a clinical breast exam is recommended)
- A Pap test **every 3 years or** Pap w/HPV co-testing every 5 years unless a prior Pap was abnormal
- Follow-up office visits and/or tests whenever there is an abnormal screening result

STOP – Provider to finish

# VISIT SUMMARY

☐ Sage ☐ SagePlus

Sage Encounter Number
Assign a new number for each visit

___ ___ ___ ___ ___ ___

Name ______________________________ Visit Date _____/_____/_____

Chart # ______________________________

Patient's Height _____ft.__in. Weight ______ lbs. Blood Pressure______/______ at today's visit

## PATIENT HISTORY

| Screening prior to this visit: | Yes ⇨ | Record month/year of prior exam/test | Never had exam/test | Or | Don't know if exam/test ever done | Or |
|---|---|---|---|---|---|---|
| Clinical breast exam | ☐ ⇨ | _____/_____mo/yr | ☐ | | ☐ | |
| Mammogram | ☐ ⇨ | _____/_____mo/yr | ☐ | | ☐ | |
| Pap test | ☐ ⇨ | _____/_____mo/yr | ☐ | | ☐ | |

**Risk Assessment (Breast Cancer)** ☐ **Average** ☐ **High** ☐ **Not Assessed**

## SAGE SERVICES PROVIDED THIS VISIT

**Results Counseling only,** to review prior Sage screening abnormality ☐ Breast abnormality ☐ Cervical abnormality

**Does the patient report breast symptoms?** ☐ Yes ☐ No

**Does the patient report family history of breast cancer?** (parent, sibling, child only) ☐ Yes ☐ No

**Clinical Breast Exam (CBE) done at visit date listed above?**

☐ Yes

**(If yes, CBE Findings for this exam)**

☐ **Normal CBE,** breast cancer not suspected

☐ **Benign CBE,** breast cancer not suspected *(i.e., fibrocystic changes, diffuse lumpiness, or nodularity)*

☐ **CBE Suspicious for breast cancer,** diagnostic evaluation required, other than mammogram (i.e. discrete palpable mass, bloody/serous nipple discharge, nipple/areolar scaliness, skin dimpling/retraction)
Suspicious CBE Description ______________________________
________________________________________________
________________________________________________

☐ No, CBE not done

☐ Patient refused CBE

**Breast Ultrasound ordered or done this visit?**

☐ No, not indicated
☐ Yes
☐ Patient Refused

**Mammogram ordered or done this visit?**

☐ Yes, routine screening
☐ Yes, to evaluate symptoms or prior abn.
☐ No, not indicated
☐ Patient refused

**Pap services done at visit date listed above?**

☐ Yes, routine screening Pap
☐ Yes, surveillance Pap – prior abnormal
☐ Yes, after primary HPV
☐ No, HPV only
☐ No, not indicated
☐ No, patient had a hysterectomy

**HPV services done at visit date listed above?**

☐ Yes, Co-Test
☐ Yes, Reflex
☐ Yes, Primary HPV only
☐ No, not indicated

**Colposcopy done at visit date listed above?**

☐ No, not indicated
☐ Yes, with Cervical Biopsy and ECS
☐ Yes, with Cervical Biopsy only
☐ Yes, with ECS only
☐ Yes, No pathology sent

**(ECS=Histological Endocervical Sampling)**

**Indication for Colposcopy this visit:**

☐ ASC-US
☐ ASC-H
☐ LSIL
☐ HSIL
☐ Atypical Glandular Cells
☐ Surveillance Colposcopy
☐ Other:____________________
____________________________

**Abnormal Pap date** ____/____/____
mo day yr

**Other Cervical Services:**

Endometrial Biopsy done at this visit for prior Sage Pap with Glandular or Endometrial Cell findings for woman over 40? ☐ Yes ☐ No

**Risk Assessment (Cervical Cancer)** ☐ **Average** ☐ **High** ☐ **Not Assessed**

**COMMENTS:**

**Please complete and return via fax:**
**Fax: 1-877-495-7545**
**Note: Incomplete forms will delay payment of claims.**

(Rev. 12/2020
#52698

Printed on Recycled Paper