BreastScreenNT PERSONAL INFORMATION and CONSENT form

Please check that all the information is correct. If not, update it.

Family Name | **First Name** | **Middle Name**

Hospital Registration Number (HRN) (If Known): __ __ __ __ __ __ __ __ __ __

Medicare No __ __ __ __ __ __ __ __ __ __ __ **Card Ref No** _____ **Expiry Date** _____/_____

Postal Address

Residential Address *(if different)*

Mobile | **Work** | **Home**

Email

For confidentiality reasons all result letters are sent by post.

Date of birth (dd/mm/yyyy)

Family name at birth (Maiden name)

Country of birth

Do you speak a language other than English at home? Yes ☐ No ☐

If "Yes", please write the language spoken at home: ……..

Are you of Aboriginal or Torres Strait Islander origin? Prefer not to state ☐

Yes ☐ No ☐

If "**Yes**", are you

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Do you have breast Implants?

If yes, please see reception for additional information Yes ☐ No ☐

Please turn over page for remaining questions

Administration use only

D/E……..… date……/……/…..……

QA……..…..….date……/……/…..……

Medicare card sighted	**Yes/No**
Double appointment required	**Yes/No**
Interpreter required	**Yes/No**

PERSONAL INFORMATION

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Would you like a copy of your results sent to your Practice/Health Clinic? Yes ☐ No ☐

You will receive the results of your mammogram by post, but it would also be useful for your practice/clinic to be informed. If "Yes", please provide the name and address of your practice/clinic.

Practice Name:
Practice / Clinic Address:

☐ **Do not send my results to My Health Record**

Have you had a mammogram before? Yes ☐ No ☐ **Approximate Year……..…….....**

Where?

☐ **BreastScreenNT**

☐ **Other BreastScreen – State…….. Town…….**

☐ **Private – Practice Name..…….. Location……**

I consent to BreastScreenNT getting my previous mammograms from other BreastScreen Services, Radiology practices or Medical Health Provider. Yes ☐ No ☐

I consent to BreastScreenNT providing a copy of my mammogram to other BreastScreen Services, Radiology practices or Medical Health Provider on request. Yes ☐ No ☐

SCREENING CONSENT

I agree to have a mammogram. I understand that I can withdraw my consent at any time.

I understand that a screening mammogram does not find all breast cancers, nor does it prevent breast cancer.

I agree that my information be kept so that reminder letters can be sent for future appointments

If I have other tests directly related to this breast x-ray, I agree that this service may obtain copies of the test results.

I agree that my information may be used in studies, research or monitoring of the BreastScreen Australia program, which may be published and **I will not be identified in the process**.

Signature ……. **Date……..……/……..……/……..……**

Full Name ……..……..……..……..

(Please PRINT)

PERSONAL INFORMATION