SCREEN FOR LIFE (SFL)
Registration Form

Health Promotion Board

Section A: *Please fill in the doctor and clinic information in this section.*

Clinic Information				
	Doctor's Name:	______________________	**MCR no.:**	__________
	Clinic Name:	______________________	**HCI Code:**	__________
	Clinic Address:	______________________	**Tel. no.:**	__________

Section B: *Please fill in client information in this section and delete * accordingly.*

Client Information						
	Client's Name:	______________________			**Gender:**	M / F *
	NRIC no.:	__________	**DOB:**	__________ *(dd/mm/yyyy)*	**Citizenship:**	SC / PR *
	Address:	______________________			**Home/Office:**	__________
	Postcode:	__________	**Email:**	______________________	**Mobile:**	__________

Section C: *Please tick the test(s) that you are ordering, and tick the relevant indicators for each test in this section.*

Date of screening:	

(dd/mm/yyyy)

☐ **Cardiovascular Disease Risk Screening** *(Hypertension, Diabetes, Lipid Disorders and Obesity)*

Episode	**Biometric Measurements**
☐ 1st Test ☐ Diagnostic/Confirmatory Test	BP: ________ *(systolic)* ________ *(diastolic)* mmHg
Type of Diagnostic/Confirmatory Test	Weight: ________ kg *(Up to 1 decimal place)*
☐ Repeat Fasting Venous Glucose Test	Height: ________ metres *(Up to 2 decimal places)*
☐ Oral Glucose Tolerance Test (OGTT)	

☐ **Cervical Cancer** *(for women 25 years old and above)*

Episode	**Specimen Source**
☐ 1st Screen ☐ Repeat Screen	☐ Cervical OS ☐ Endocervix ☐ Lat. vaginal wall ☐ Vault smear
LMP: ______________ *(dd/mm/yyyy)*	☐ Others

☐ **Colorectal Cancer** *(for clients 50 years old and above)*

Date of collection of FIT kits:	

(dd/mm/yyyy)

Individual/Family Risk Factors

Cardiovascular Diseases	**Cervical Cancer**	**Colorectal Cancer**
Do you have any known risk factors such as:		
☐ Being overweight (BMI above 23kg/m^2) ☐ Smoking ☐ History of gestational diabetes mellitus ☐ Family history of cardiovascular diseases ☐ Others: ______________	☐ History of Human Papilloma Virus (HPV) infection ☐ Immunocompromised conditions ☐ Family history of cervical cancer ☐ Others: ______________	☐ Inflammatory Bowel Disease / Crohn's Disease ☐ Family history of colorectal cancer ☐ Others: ______________

Consent For Participation *(Please ensure client completes this section)*

I, the undersigned, have read and understood Section D on page 2 of this form and consent to participate in Health Promotion Board's Screen for Life programme.

Explained by:

______________________________ ______________________________

Name and Signature or Thumbprint of Client / Date Name and Signature of Witness / Date

☐ *I do not consent to HPB disclosing the Information and my past screening and follow-up information to HPB's Collaborators for the purposes mentioned in Section D Para 4 on page 2*

Laboratory's Copy

Section D: *Consent to participate in the Screen for Life programme (To be explained to client)*

1. Consent to Screen and Follow-up

By participating in this programme, ("Programme"), I consent to undergo health screening tests ("Tests") for one or more of the following: chronic diseases (obesity, diabetes, high blood pressure and high blood cholesterol) and / or cancers (breast and cervical cancer for women and colorectal cancer) and / or functional screening and follow-up by Health Promotion Board (HPB) appointed healthcare institutions/clinics/ service providers participating in the Programme ("Service Providers").

I understand that I should see a doctor if any of my Test results is abnormal. I further understand that there are limitations to the Tests and that they are not conclusive in detecting or ruling out medical risk factors or conditions. I should see a doctor if I feel unwell or have any symptoms even if the Test results are normal.

Depending on my Test results, I may be contacted and/or referred by HPB or the Service Providers for post-screening follow-up within the Programme.

2. Collection and Use of Information

I acknowledge that my personal data and relevant screening and follow-up information, including the Test results (collectively, the "Information") will be collected and used by HPB and Service Providers for the purposes of administering the Programme, conducting the Tests, and managing and implementing follow-up action arising from the Test results. I also acknowledge that the Information will be retained by HPB, the National Electronic Health Record (NEHR) and Ministry of Health (MOH) and that aggregate/de-identified Information may be used for research, statistical and planning purposes.

3. Authorisation

I authorise HPB and Service Providers to approach HPB's collaborators[1] and/or other healthcare institutions/clinics which are in the possession of my screening, follow-up, further assessment and/or treatment records relevant to HPB's Screening Programmes to request for such records (if any) for the purposes of patient care, treatment or clinical / programme review.

4. Disclosure of Information

Unless otherwise indicated in Page 1, I consent to HPB directly disclosing the Information and my past screening and follow-up information[2] to HPB's collaborators[1] (where necessary) for the purposes of checking if I require re-screening, further tests, follow-up action and/or referral to community programmes/activities.

End of Page 2

[1] Collaborators refer to organisations / institutions in partnership with HPB for the provision of screening and follow-up related services.
[2] Refers to Participant's past screening and follow-up information under all of HPB Screening Programmes.