SCREEN FOR LIFE (SFL)
Registration Form

*Please fill in **ALL** fields and delete* accordingly.*

Section A

Clinic Information

HCI Code: _____ (Please fill in the HCI code clearly to facilitate approval of claims)

Doctor's Name: _____ **MCR no.:** _____

Clinic Name: _____ **Tel. no.:** _____

Clinic Address: _____

Section B

Client Information

Client's Name: _____ **Sex:** M / F *

NRIC no.: _____ **DOB:** _____ *(dd/mm/yyyy)* **Citizenship:** SC / PR *

Address: _____ **Contact No.:** _____

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

Date of initial test: *(dd/mm/yyyy)*		**Date of repeat test:** *(dd/mm/yyyy)*	

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

Initial Test	**Repeat Test (☐ 1st Repeat ☐ 2nd Repeat)**
☐ HbA1c + Lipid Profile (☐ Non-fasting ☐ Fasting) *(**EDTA** tube + plain tube)*	☐ Oral Glucose Tolerance Test (OGTT) *(**Fluoride** tube)*
☐ Fasting Venous Glucose + Lipid Profile *(**Fluoride** tube + plain tube)*	☐ Repeat Fasting Venous Glucose *(**Fluoride** tube)*

Biometric Measurements		
BP: _____ mm/Hg *(systolic)* _____ mm/Hg *(diastolic)*	Height: _____ metres *(2 decimal places)* Weight: _____ kg *(1 decimal place)*	Waist Circumference: _____ cm *(1 decimal place)*

☐ **Cervical Cancer Screening**

Initial Test	**Repeat Test (☐ 1st Repeat ☐ 2nd Repeat)**
☐ HPV DNA *(women 30 years & older based on year of birth)*	☐ Repeat HPV DNA *(only if initial test was a HPV DNA test; to be done no earlier than 9 months from the initial test date)*
☐ Pap Test *(women 25 to 29 years old based on year of birth)*	☐ Repeat Pap Test *(only if initial test was a Pap test)*

Specimen Source
☐ Cervical OS ☐ Endocervical ☐ Cervical OS/Endocervical ☐ Others

☐ **Colorectal Cancer Screening**

Kit Expiry Date: _____

TWO copies of this completed form are to be given to the client for insertion into the envelopes with the FIT kits.

Section D: Client Consent for Participation

I, the undersigned, have read and understood **Section E on page 2** of this form and consent to participate in Health Promotion Board's Screen for Life (SFL) programme ("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 (as defined in Page 2) and my post screening and follow-up information under the Programme to HPB's collaborators (as defined in Page 2) for the purposes mentioned in Section E para 4 on page 2*

Section E: 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.

[1] Collaborators refer to organisations / institutions in partnership with HPB for the provision of screening and follow-up related services.

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SCREEN FOR LIFE (SFL)
Registration Form

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Section A

Clinic Information

HCI Code: _____ (Please fill in the HCI code clearly to facilitate approval of claims)

Doctor's Name: _____ **MCR no.:** _____

Clinic Name: _____ **Tel. no.:** _____

Clinic Address: _____

Section B

Client Information

Client's Name: _____ **Sex:** M / F *

NRIC no.: _____ **DOB:** _____ *(dd/mm/yyyy)* **Citizenship:** SC / PR *

Address: _____ **Contact No.:** _____

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

Date of initial test: *(dd/mm/yyyy)*		**Date of repeat test:** *(dd/mm/yyyy)*	

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

Initial Test	**Repeat Test (☐ 1st Repeat ☐ 2nd Repeat)**
☐ HbA1c + Lipid Profile (☐ Non-fasting ☐ Fasting) *(**EDTA** tube + plain tube)*	☐ Oral Glucose Tolerance Test (OGTT) *(**Fluoride** tube)*
☐ Fasting Venous Glucose + Lipid Profile *(**Fluoride** tube + plain tube)*	☐ Repeat Fasting Venous Glucose *(**Fluoride** tube)*

Biometric Measurements		
BP: _____ mm/Hg *(systolic)* _____ mm/Hg *(diastolic)*	Height: _____ metres *(2 decimal places)* Weight: _____ kg *(1 decimal place)*	Waist Circumference: _____ cm *(1 decimal place)*

☐ **Cervical Cancer Screening**

Initial Test	**Repeat Test (☐ 1st Repeat ☐ 2nd Repeat)**
☐ HPV DNA *(women 30 years & older based on year of birth)*	☐ Repeat HPV DNA *(only if initial test was a HPV DNA test; to be done no earlier than 9 months from the initial test date)*
☐ Pap Test *(women 25 to 29 years old based on year of birth)*	☐ Repeat Pap Test *(only if initial test was a Pap test)*

Specimen Source
☐ Cervical OS ☐ Endocervical ☐ Cervical OS/Endocervical ☐ Others

☐ **Colorectal Cancer Screening**

Kit Expiry Date: _____

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Explained by:

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SCREEN FOR LIFE (SFL)
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Section A

Clinic Information

HCI Code: _____ (Please fill in the HCI code clearly to facilitate approval of claims)

Doctor's Name: _____ **MCR no.:** _____

Clinic Name: _____ **Tel. no.:** _____

Clinic Address: _____

Section B

Client Information

Client's Name: _____ **Sex:** M / F *

NRIC no.: _____ **DOB:** _____ *(dd/mm/yyyy)* **Citizenship:** SC / PR *

Address: _____ **Contact No.:** _____

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

Date of initial test: *(dd/mm/yyyy)*		**Date of repeat test:** *(dd/mm/yyyy)*	

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

Initial Test	**Repeat Test (☐ 1st Repeat ☐ 2nd Repeat)**
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Biometric Measurements		
BP: _____ mm/Hg *(systolic)* _____ mm/Hg *(diastolic)*	Height: _____ metres *(2 decimal places)* Weight: _____ kg *(1 decimal place)*	Waist Circumference: _____ cm *(1 decimal place)*

☐ **Cervical Cancer Screening**

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Specimen Source
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Clinic Address:	_____			

Section B

Client Information					
Client's Name:	_____			**Sex:**	M / F *
NRIC no.:	_____	**DOB:**	_____ *(dd/mm/yyyy)*	**Citizenship:**	SC / PR *
Address:	_____			**Contact No.:**	_____

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