NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

COLORECTAL CANCER SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

TO BE COMPLETED BY PATIENT

The WTC Health Program provides colorectal cancer screening for WTC-certified members who meet the U.S. Preventive Service Task Force criteria (USPSTF). Information about colorectal cancer screening is provided in your folder. Common ways to screen include a colonoscopy or yearly stool testing. Colonoscopy can be scheduled at Bellevue or Elmhurst Hospital. Stool testing can be performed at any of WTC EHC sites.

Please complete these questions. Thank you.

1. Are you currently between 50 – 75 years old?	☐ Yes ☐ No **If NO, please stop here**
2. Have you had a colonoscopy within the last 10 years?	☐ Yes Month _____ Year _____ ☐ No ☐ I Don't Know
3. Do you have a diagnosis of polyps in your colon?	☐ Yes ☐ No ☐ I Don't Know
4. Do you have Inflammatory Bowel Disease?	☐ Yes ☐ No ☐ I Don't Know
5. Do any of your parents, siblings or children have colorectal cancer?	☐ Yes ☐ No ☐ I Don't Know
6. Do you have colorectal cancer?	☐ Yes ☐ No ☐ I Don't Know
7. If you fit criteria which screening test would you prefer to have?	☐ Colonoscopy ☐ Stool (FIT) test ☐ None / Refused

TO BE COMPLETED BY NURSE OR OTHER (Name _____)

8. Does patient meet inclusion criteria for routine colorectal screening?	☐ Yes ☐ No **YES, if patient, (MUST FIT ALL CRITERIA)** ✓ **is between 50 – 75 years old** ✓ **has not had a colonoscopy within last 10 years**
9. Does patient meet criteria for more frequent screening or diagnostic evaluation (symptoms, family history, polyps, IBD, cancer)	☐ Yes ☐ No **If YES to <u>any</u> of questions #3 - 6, discuss with provider**
10. Is there an extenuating circumstance?	☐ Yes ☐ No **If YES, do <u>not</u> schedule routine screening**

Version Updated. 1/15/16, 2/16/16, 7/12/18, 5/9/19, 8/28/19, 10/25/19

ROUTINE COLORECTAL SCREENING

If the answers to question # 8 is YES and questions #9 and #10 are NO, patient meets inclusion criteria for routine screening. Schedule a routine colorectal screening.

11. If patient meets criteria, which colorectal screening approach does the patient prefer?	☐ Colonoscopy ☐ FIT ☐ None / Refused ✓ **Provider to note in EMR if patient refuses screening**
12. If patient would like to have colonoscopy screening, where would they prefer to have it done?	☐ Bellevue ☐ Elmhurst ☐ Outside Provider ✓ **Provider to note in EMR if patient wants screening with external provider.** ✓ **If screening is preferred at Bellevue, Nurse to ask Provider to request appointment for colonoscopy evaluation with WTC GI in EMR**
13. If patient would like to have FIT testing, where would they prefer to have it done?	☐ Bellevue ☐ Elmhurst ☐ Gouverneur ✓ **Nurse to ask Provider to order FIT in EMR** ✓ **Nurse provides FIT materials with instructions** ✓ **Front desk schedules patient for 1 year monitoring with FIT testing.** ✓ **Provider gets results in queue**

Version Updated. 1/15/16, 2/16/16, 7/12/18, 5/9/19, 8/28/19, 10/25/19

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WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

MAMMOGRAPHY SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

TO BE COMPLETED BY PATIENT

The WTC Health Program provides routine breast cancer screening for WTC-certified members who meet the US Preventive Services Task Force (USPSTF) criteria. Information about breast cancer screening is provided in your folder. The USPSTF recommends a mammogram every two years for women between the ages of 50 – 74. If there is a history of breast cancer in the family, screening is recommended to start at age 40. These recommendations apply to women who do not have a known risk.

Please complete these questions. Thank you.

1. Are you female?	☐ Yes ☐ No **If NO, please stop here.**
2. What is your age?	☐ Less than 40 ☐ 40 – 49 ☐ 50 – 75 ☐ Greater than 75 **If you are less than 40 years old or greater than 75 years old, please stop here.**
3. Have you had a mammogram in the previous two (2) years?	☐ Yes ☐ No ☐ I Don't Know **If you had a mammogram in the past two (2) years, please indicate the month and year.** Month _____ Year _____
4. Has your mother, sister or child been diagnosed with breast cancer?	☐ Yes ☐ No ☐ I Don't Know
5. Do you have a history of any of the following? • pre-existing breast cancer • a previously diagnosed high risk breast lesion • a known genetic risk (BRCA1 or BRCA2) • familial breast cancer syndrome	☐ Yes ☐ No ☐ I Don't Know
6. If you fit criteria for breast cancer screening, where would you prefer to have it done?	☐ My own provider ☐ Bellevue ☐ Gouverneur ☐ Elmhurst

TO BE COMPLETED BY NURSE (Name of RN _____)

7. Does patient fit criteria for routine breast cancer screening?	☐ Yes ☐ No **YES, if patient is female and between ages 50 – 75 or patient is between ages 40-49 and answered YES to question #4**
8. Does patient want a mammogram at Bellevue, Gouverneur or Elmhurst?	☐ Yes ☐ No **If patient answers YES to question #6 and fits criteria, alert Provider to order in EMR at Bellevue, Gouverneur or Elmhurst**
9. Is patient at risk for breast cancer?	☐ Yes ☐ No **If YES to question #5, refer patient to provider for diagnostic referral**

Version Updated. 7/12/16, 7/23/18, 5/9/19, 10/25/19

NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

CERVICAL CANCER SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

TO BE COMPLETED BY PATIENT

The WTC Health Program provides cervical cancer screening for WTC-certified members who meet the U.S. Preventive Service Task Force criteria (USPSTF). A PAP smear is recommended every 3 years for women between the ages of 21-65 or a combined PAP and screening for the human papilloma virus (HPV) is recommended every 5 years for women between the ages of 30-65.

Please complete these questions. Thank you.

1. Are you biologically female?	☐ Yes ☐ No **If NO, please stop here**
2. Are you between 21 and 65 years old?	☐ Yes ☐ No **If NO, please stop here**
3. Do you still have your cervix?	☐ Yes ☐ No ☐ I Don't Know **If NO, please stop here**
4. When was your last pap smear?	Month _____ Year _____ ☐ I Don't Know
5. Do you have cervical cancer or abnormal PAP smear?	☐ Yes ☐ No ☐ I Don't Know
6. If you fit criteria for cervical cancer screening, where would you prefer to have it done?	☐ My own provider ☐ Bellevue ☐ Gouverneur ☐ Elmhurst

TO BE COMPLETED BY NURSE **Name of RN** _____

7. Does patient fit criteria for routine cervical cancer screening?	☐ Yes ☐ No **YES, if patient (MUST FIT ALL CRITERIA)** ✓ **Is biologically female** ✓ **Between ages 21 – 65** ✓ **Has a cervix or doesn't know** ✓ **Has NOT had a PAP smear within the past three (3) years.** ✓ **Does not have cervical cancer or abnormal PAP screening**
8. Does patient need diagnostic cervical cancer screening?	☐ Yes ☐ No ☐ I Don't Know (Yes to #5, has history of cervical cancer or abnormal PAP smear)
9. Is the patient interested in cervical cancer screening through the WTC EHC?	☐ Yes ☐ No ☐ I Don't Know **If YES, Nurse to alert Provider to order consultation in EMR with GYN clinic at Bellevue, Gouverneur or Elmhurst**

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NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

LUNG CANCER SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

TO BE COMPLETED BY ALL PATIENTS

The US Preventive Services Task Force (USPSTF) recommends annual screening for lung cancer for adults at risk. The WTCHP provides lung cancer screening for WTC-certified members who meet the USPSTF criteria. Information about lung cancer screening is in your folder. The screening consists of a low-dose computed tomography of the chest (CT scan). This questionnaire is part of the screening process to determine if you are eligible. If eligible, we will arrange the CT scan at Bellevue Hospital.

Please complete these questions. Thank you.

1. Are you between 55 and 80 years old?	☐ Yes ☐ No **If NO, please stop here**
2. Do you currently smoke or have you quit smoking within the last fifteen (15) years?	☐ Yes ☐ No **If NO, please stop here**
3. If you quit smoking, when did you quit?	Month_____ Year _____ ☐I Can't Remember
4. During the time you smoked, **on average**, how many packs of cigarettes did you smoke each day?	_____ packs per day *20 cigarettes = 1 pack*
5. For how many years did you smoke cigarettes regularly?	_____ years
6. Have you ever been diagnosed with lung cancer?	☐ Yes ☐ No
7. If you are currently smoking, are you interested in smoking cessation?	☐ Yes ☐ No

TO BE COMPLETED BY PROVIDER (Name of Provider _____)

INCLUSION CRITERIA

8. Does the patient fit ALL the inclusion criteria for routine lung cancer screening	☐ Yes ☐ No ☐ I Don't Know **YES, If patient** ✓ **is age 55 – 80** ✓ **smoker within past 15 years** ✓ **≥ 30 p-y hx** *(# of packs per day X # of years smoked = packs-yr)*

EXCLUSION CRITERIA

9. Does the patient need other lung or lung cancer diagnostic evaluation? Ex. Symptoms of cough, blood, weight loss, pneumonia	☐ Yes ☐ No
10. Does the patient have extenuating circumstances that preclude lung cancer screening?	☐ Yes ☐ No ☐ I Don't Know
11. Has the patient had a CT scan within the past 12 months?	☐ Yes ☐ No ☐ I Don't Know

ASSESSMENT

12. Does the patient fit all inclusion criteria and no exclusion criteria?	☐ Yes ☐ No **YES, if patient answers "Yes" to <u>any</u> of questions #8 – #11** **If NO, please stop here**
13. Is the patient interested in lung cancer screening through the WTC EHC?	☐ Yes ☐ No ☐ I Don't Know
14. Has the WTC provider ordered a Lung Cancer Screening CT at Bellevue Hospital	☐ Yes ☐ No

<u>Instructions to Schedule Lung Cancer Screening at Bellevue Hospital</u>

Under MEDICATIONS / ORDER, order a CT Chest Low Dose Initial Screening. You will be asked to complete questions under the order. These have been included in the WTC Lung Cancer Screening Questionnaire.

<u>Instructions If Patient Wants Smoking Cessation</u>

1. Write prescription for smoking cessation aids.
2. Provide 2 weeks of gum and / or Nicorette patch, depending on patient's preference.
3. Put smoking cessation order in EMR (Bellevue and Gouverneur only).
4. Patient will receive follow up from smoking cessation counselor, Jesus 917- 239- 3850 (Bellevue) and Lisette Mojica (Gouverneur).
5. Refer patients at Elmhurst to the Smoking Cessation Program (718-334-2550) or the counselor, Bienvenido Medrano (718) 334-1517.
6. Alternatively, patient contacts New York State 1-866-NY-QUITS (1-866-697-8487) or https://www.health.ny.gov/publications/3485/