SCREEN FOR LIFE (SFL)
Registration Form

Health Promotion Board

*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: ________________ **Gender:** M / F *

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

Address: ________________ **Home/Office:** ________________

Postal Code: ________ **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)*

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

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

☐ **Cervical Cancer Screening** LMP: ________________ *(dd/mm/yyyy)*

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 an HPV DNA test)*
☐ 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 ☐ Endocervix ☐ Lat. vaginal wall ☐ Vault smear ☐ Others

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

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: 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) ☐ Tobacco use e.g. cigarette 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: ________________

Section E: Client Consent for Participation

I, the undersigned, have read and understood **Section F 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 past screening and follow-up information under the Programme to HPB's collaborators (as defined in Page 2) for the purposes mentioned in Section F para 4 on page 2*

Section F: 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.
[2] Refers to Participant's past screening and follow-up information under all of HPB Screening Programmes.

SCREEN FOR LIFE (SFL)
Registration Form

Health Promotion Board

*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: __________ **Gender:** M / F *

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

Address: __________ **Home/Office:** __________

Postal Code: __________ **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)*

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

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

☐ **Cervical Cancer Screening** LMP: __________ *(dd/mm/yyyy)*

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 an HPV DNA test)*
☐ 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 ☐ Endocervix ☐ Lat. vaginal wall ☐ Vault smear ☐ Others

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

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: 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) ☐ Tobacco use e.g. cigarette 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: __________

Section E: Client Consent for Participation

I, the undersigned, have read and understood **Section F 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 past screening and follow-up information under the Programme to HPB's collaborators (as defined in Page 2) for the purposes mentioned in Section F para 4 on page 2*

Section F: 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.
[2] Refers to Participant's past screening and follow-up information under all of HPB Screening Programmes.

SCREEN FOR LIFE (SFL)
Registration Form

Health Promotion Board

*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: ________ **Gender:** M / F *

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

Address: ________ **Home/Office:** ________

Postal Code: ________ **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)*

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

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

☐ **Cervical Cancer Screening** LMP: ________ *(dd/mm/yyyy)*

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 an HPV DNA test)*
☐ 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 ☐ Endocervix ☐ Lat. vaginal wall ☐ Vault smear ☐ Others

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

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: 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) ☐ Tobacco use e.g. cigarette 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: ________

Section E: Client Consent for Participation

I, the undersigned, have read and understood **Section F 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 past screening and follow-up information under the Programme to HPB's collaborators (as defined in Page 2) for the purposes mentioned in Section F para 4 on page 2*

Section F: 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.
[2] Refers to Participant's past screening and follow-up information under all of HPB Screening Programmes.

ScreenforLife

SCREEN FOR LIFE (SFL)

Registration Form

Health Promotion Board

*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: ____________ **Gender:** M / F *

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

Address: ____________ **Home/Office:** ____________

Postal Code: ____________ **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)*

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

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

☐ **Cervical Cancer Screening** LMP: ____________ *(dd/mm/yyyy)*

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 an HPV DNA test)*
☐ 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 ☐ Endocervix ☐ Lat. vaginal wall ☐ Vault smear ☐ Others

☐ **Colorectal Cancer Screening** *(for clients 50 years old and above)* **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: 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) ☐ Tobacco use e.g. cigarette 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: ____________

Section E: Client Consent for Participation

I, the undersigned, have read and understood **Section F 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 past screening and follow-up information under the Programme to HPB's collaborators (as defined in Page 2) for the purposes mentioned in Section F para 4 on page 2*

Section F: 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.
[2] Refers to Participant's past screening and follow-up information under all of HPB Screening Programmes.