# *Community FIT Kit Request Form for Men & Women 45-74*

4/2025

FIT #: _____

1. **ALL QUESTIONS MUST BE ANSWERED.** Please print clearly.
2. Read and sign.
3. Give the **COMPLETED** form to the kit provider and mail the completed test kit in the return envelope provided.

| **First Name** | Middle Initial | **Last Name** | Maiden Name |
|---|---|---|---|
| | | | |

| **Birthdate** / / | **Address** | **Best Phone Number to Reach You:** ( ) |
|---|---|---|
| | | |

| **City** | **County** | **State** | **Zip** |
|---|---|---|---|
| | | | |

**Gender:**
❑Male ❑Female

**Are you of Hispanic/latina(o) origin?** ❑Yes ❑No ❑Unknown

**Primary language spoken in your home?**
❑English ❑Spanish ❑Vietnamese ❑Other_____

**What race or ethnicity are you?** ***(check all boxes that apply)***

❑American Indian/Alaska Native Tribe: _____
❑Black/African American
❑Mexican American
❑White
❑Asian
❑Pacific Islander/Native Hawaiian
❑Other _____
❑Unknown

**Do you have health insurance?**
❑Yes ❑No
*(**Note:** Your health plan will not be billed for this test, nor will they be notified of your individual test results.)*

**Have you ever been screened for colorectal cancer?**
❑No
❑Yes, within last year
❑Yes, more than a year ago
❑I don't know

**Who is your primary care doctor?** Name of doctor: _____
Name of clinic: _____ City: _____

***Disclosure Statement*** **-** This test is used only to detect hidden blood in the stool, which can be a sign of several conditions including hemorrhoids, colon polyps, cancer, diverticulitis, and ulcers. A positive test result means you should contact your family doctor for a follow-up examination. A negative test result does not mean that you do not have cancer. A negative result means you should be screened annually. You should discuss the American Cancer Society's recommendations for colorectal screenings with your doctor to best determine how often you should be examined. My health care provider and laboratory, can give results of my FIT Kit and colonoscopy results to NCP for payment and quality assurance. No information will be shared with outside sources.

***Authorization to Release Information*** **-** I hereby authorize the release of my stool test results; the information contained on my registration form and recommended related tests to the testing facility and my doctor. This information, as well as patient and physician identity, will be kept strictly confidential and used only for statistical purposes by the Nebraska Colon Cancer Screening Program. The recipient of this patient information is prohibited from disclosing the information to any other party and is required to destroy the information after the need has been fulfilled.

**Please Print Your Name (first, middle last)** _____

**Your Signature:** _____ **Date:** _____/_____/_____

**If you have questions, please contact the Nebraska Women's and Men's Health Programs:**

Nebraska Women's and Men's Health Programs || 301 Centennial Mall South || P.O. Box 94817 || Lincoln, NE 68509-4817

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Women's & Men's Health Programs
BREAST. CERVICAL. COLON. HEART. SCREENING
Every Woman Matters
Nebraska Colon Cancer Screening Program