Participant Details

NATIONAL BOWEL CANCER SCREENING PROGRAM

Please complete and post this form with your completed test samples.
If you have any questions, please contact the National Bowel Cancer Screening Program Contact Centre **1800 627 701** or visit **www.ncsr.gov.au**
Please use a black pen and write in BLOCK LETTERS in the boxes provided.

1 Name and contact details

IMPORTANT:
The test should ONLY be completed by the person who received the bowel screening kit.

Family name

Given name(s)

Address line 1

Address line 2

Suburb/Town/City

State Postcode

Changing your name and address details in the National Bowel Cancer Screening Program will not change your Medicare details. If you need to change your Medicare details please call 13 20 11.

Work telephone Mobile telephone

Home telephone

Email address

2 Nominated doctor/medical practice details (a copy of your test results will be sent to this practice)

Doctor's family name

Doctor's given name

Medical Practice name

Medical Practice Address line 1

Address line 2

Suburb/Town/City

State Postcode Provider number (if known)

NBCSP C001 1904

3 Test sample details (Participants, please record)

Date first sample collected (dd/mm/yyyy) / /

Date second sample collected (dd/mm/yyyy) / /

4 **What gender do you identify as?** Male ☐ Female ☐ Other ☐

5 **Do you identify as Aboriginal or Torres Strait Islander origin? (if known)**

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Non Indigenous ☐ Prefer not to answer ☐

6 **Do you ever need someone to help you with, or be with you for, self care activities?**
For example, doing everyday activities such as eating, showering or dressing.

No ☐ Yes sometimes ☐ Yes always ☐ Prefer not to answer ☐

7 **Do you ever need someone to help you with, or be with you, for body movement activities?**
For example, getting out of bed, moving around at home or at places away from home.

No ☐ Yes sometimes ☐ Yes always ☐ Prefer not to answer ☐

8 **Do you ever need someone to help you with, or be with you, for communication activities?**
For example, understanding or being understood by others.

No ☐ Yes sometimes ☐ Yes always ☐ Prefer not to answer ☐

9 **If you answered 'Yes' to questions 6, 7 or 8, what are your reasons for assistance?**
Mark all applicable reasons.

☐ Short-term health condition (lasting less than six months)

☐ Long-term health condition (lasting more than six months)

☐ Disability (lasting more than six months) ☐ Old age

☐ Difficulty with English language ☐ Prefer not to answer

☐ Other cause (please specify)

10 **What is your country of origin? (if known)**

What is your preferred language spoken at home? (if known)

Do you require interpreter services to understand English?

No ☐ Yes ☐

NBCSP C001 1904

11 Please complete this section if you would like to authorise another person to talk to staff of the National Bowel Cancer Screening Program on your behalf.

Family name

Given name(s)

Date of birth (dd/mm/yyyy) / / Preferred phone number

Email address

Postal address line 1

Postal address line 2

Suburb/Town/City

State Postcode

Their relationship to you:

- ☐ Parent
- ☐ Legal guardian
- ☐ Legal representative - Enduring Power of Attorney
- ☐ Legal representative - Trustee
- ☐ Healthcare Provider ▶ is the same person as stated in Question 2? ☐ Yes ☐ No
- ☐ Other ▶ (please specify)

For example, carer or family member

The person who is acting on your behalf will be authorised to talk to staff of the National Bowel Cancer Screening Program. If you wish to update these details at any time, please call the National Bowel Cancer Screening Program Contact Centre on 1800 627 701.

12 Your privacy

Your personal information is protected by law, including the *Privacy Act 1988 (Cth)* and the *National Cancer Screening Register Act 2016*, and is being collected for the Australian Government Department of Health, for the purpose of including information about you on the National Cancer Screening Register (NCSR) as part of the National Bowel Cancer Screening Program. Personal information about you has also been collected from the Department of Human Services as part of the process of inviting you to undergo screening and may be collected for follow-up after you have had a screening test.

Your information may be used by the NCSR or given to other parties to provide you with healthcare, for the purpose of research, investigation or where it is required or authorised by law or court or tribunal order.

If you require more information visit the website www.ncsr.gov.au.

NBCSP C001 1904

13 Acknowledgement

By signing below as the Participant, I confirm that I am capable of making my own decisions in relation to my health affairs. Alternatively, if signing as the personal representative on behalf of the participant, I confirm that I am legally authorised to act on the Participant's behalf.

I acknowledge that:

- by completing and returning this form and/or the test to the pathology laboratory I am agreeing to become a participant in the National Bowel Cancer Screening Program;
- by agreeing to participate in the National Bowel Cancer Screening Program I agree to being invited again in the future to complete tests during the period I am eligible to participate except during any time I opt out or defer my participation;
- by nominating my healthcare provider in Section 2 of this form, I agree to this person being updated in my profile on the National Cancer Screening Register (NCSR), to receive a copy of my test results and access details about me and be contacted if I need to be followed-up in relation to my bowel screening.
  - If only a medical practice is nominated, the results will be sent to the principal doctor in that practice, who will therefore be recorded as my doctor in the NCSR.
  - If I see another healthcare provider for bowel screening, they will also be recorded in the NCSR and will receive information about my bowel screening.
- if a personal representative has been nominated to act on behalf of the participant in Section 11 of this form, the NCSR may contact the nominated personal representative to confirm the nomination and seek further legal documentation (if required);
- I may opt out or defer my participation in the Program at any time by completing the opt out or defer advice notice available on www.ncsr.gov.au or by phoning the National Bowel Cancer Screening Program Contact Centre on 1800 627 701 (free call);
- I have read, or had explained to me, and understand the National Bowel Cancer Screening Program Information Booklet, the *Your Privacy* section of this form and the test instructions; and
- the test samples I have provided will be tested for the presence of blood, and I understand that:
  - screening tests are not always 100% accurate (as some cancers do not bleed or only bleed on and off) and therefore test results cannot be guaranteed (studies indicate that these tests detect 60–85% of cancers); and
  - if blood is found in the sample provided it is my responsibility to contact a doctor to discuss the results, the nature and risks of any further tests and to arrange for further tests following a full clinical assessment. It is not the responsibility of the Program or its employees, agents or anyone connected with this test procedure to do this for me.

AND

- I consent to the National Cancer Screening Register collecting sensitive information about my health and racial or ethnic origin for the purpose indicated in *Your Privacy.*

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Signed by: ☐ Participant OR ☐ Personal representative

14 My Health Record

My Health Record is an online summary of your key health information. For further information refer to www.myhealthrecord.gov.au.

If you have a My Health Record, pathology reports may be uploaded to that record. You do not need to give consent every time but you need to indicate what tests you **do not want** uploaded to your record **every time you have that test** performed.

When you do the National Bowel Cancer Screening Program test, your reports will be sent to My Health Record, unless you indicate you do not want this to happen by marking the box below.

☐ Do not send reports to My Health Record

15 Returning your form and test samples

Please return this form with your completed test samples in the reply paid envelope provided.

If you have already returned the test samples but did not include this form, please send it to the address below. Your test result will not be sent to you or your doctor if this form is not returned.

Sonic Healthcare
Bowel Screening
Reply Paid 89305
NORTH RYDE NSW 1670

NBCSP C001 1904