American Indian Cancer Foundation's
Screen Our Circle

☐ Enrolled #: _____

Enrolled Screen Our Circle Client Navigation Form

* Indicates required fields

Client Contact Information		
*Last Name:	*First Name:	*Birth Date (*MM/DD/YYYY*):
Address		
City:	*State:	*Zip Code:
Phone Number (home, work, cell):	Phone Number (Alternate):	
Email:		

*Navigation Services	
Navigator Name:	Form Completed (*date, MM/DD/YYYY*):
First Contact (*date, MM/DD/YYYY*): _____ Contact Type:	Second Contact (*date, MM/DD/YYYY*): _____ Contact Type: ☐ Phone ☐ Voicemail ☐ Text ☐ Email ☐ Face-to-Face ☐ Mail
Structural Barriers Assessed: ☐ Dependent Care ☐ Fear ☐ Financial ☐ Housing ☐ Insurance ☐ Language ☐ Literacy ☐ Medical Health ☐ Mental Health ☐ Transportation ☐ Other	
Navigation Complete: ☐ Yes (*indicate services*) ☐ No (*indicate reason*)	
Service type received: ☐ Navigation to completed office visits ☐ Navigation to completed pap and/or mammo ☐ Navigation to completed diagnostic services	Reason for services not received: ☐ Did not complete screening/diagnostic services ☐ Cannot locate ☐ Refused ☐ Other: _____

*Clinical Services (Please complete at least 1 box)	
Screening Services Completed: Breast: ☐ Yes (*date, MM/DD/YYYY*): _____ ☐ No Results: ☐ Normal ☐ Abnormal Cervical: ☐ Yes (*date, MM/DD/YYYY*): _____ ☐ No Results: ☐ Normal ☐ Abnormal	Diagnostic Services Completed: ☐ N/A Breast: ☐ Yes (*date, MM/DD/YYYY*): _____ ☐ No Cervical: ☐ Yes (*date, MM/DD/YYYY*): _____ ☐ No ☐ Refused ☐ Cannot locate
Cancer Diagnosis: ☐ N/A ☐ Breast Cancer ☐ Cervical Cancer Diagnosis (*date, MM/DD/YYYY*): _____	Treatment: ☐ Chemotherapy (*date, MM/DD/YYYY*): _____ ☐ Radiation therapy (*date, MM/DD/YYYY*): _____ ☐ Surgery (*date, MM/DD/YYYY*): _____