Study barcode ID

Form Approved
OMB No. 0920-xxxx
Exp. xx/xx/xxxx

# CDC CERVICAL CANCER STUDY (Cx3 Study)

## Patient Enrollment Form – [CLINIC NAME]

**First Name:** _____ **Last Name:** _____

**Date of Birth:** ☐☐ ☐☐☐☐
month year

**Provider:** **1=[Provider1]** **3=[Provider3]** **5=[Provider5]** **7=[Provider7]**
**(circle)** **2=[Provider2]** **4=[Provider4]** **6=[Provider6]** **8=[Provider8]**

**Clinic's Patient ID number:** _____

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**Selected for Patient Survey: Yes / No** **Consented to Patient Survey: Yes / No**

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**<u>If patient consented to participate in the Patient Survey complete the following section:</u>**

**PATIENT CONTACT INFORMATION:**

**Address:** _____

_____

**Phone numbers:** **Home:** _____ —_____ —_____

**Work:** _____ —_____ —_____ **Cell:** _____ —_____ —_____

**Name and address of a friend or family member who will always know where to contact patient, in case she has moved and we are having trouble contacting her.**

**Name of Friend or Relative:** _____

**Telephone Number of Friend or Relative:** _____ —_____ —_____

**Type of phone (circle): Home / Work / Cell**