

## Attachment 3

### Letter to Physicians

*Registry Logo*

*Date*

Dear Dr. «Physician\_First\_Name» «Physician\_Last\_Name»:

You are receiving this letter because one (or more) of your patients has been identified as a person who was diagnosed with invasive cervical cancer and is eligible to participate in the Case Investigation of Cervical Cancer (CICC) Study. The CICC Study is funded by the Centers for Disease Control and Prevention (CDC) and in three states around the country, including the \_\_\_ Cancer Registry. This study will include about 1,600 women who were age 21 or over at the time of their cancer diagnosis. The goal of the CICC Study is to better understand the facilitators and barriers and the case histories of cervical cancer screening and follow-up precancer.

Your patient was identified through the \_\_\_ Cancer Registry, which is mandated by law to register all newly diagnosed cancer cases in the state and to conduct special studies for cancer control and prevention. Physicians and medical institutions are protected by law from liability for the release of information to the \_\_\_ Cancer Registry.

We will contact the patient about the CICC Study unless we hear from you in two weeks. If you have a specific reason why we should not contact your patient, please sign and return the enclosed *Physician Notification Form* by confidential fax to (xxx) xxx-xxx.

We will send a letter to the patient inviting her to participate in this study. If the patient chooses to take part in this study, we will ask him/her to complete one survey and to permit a medical record review. We will keep all patient information secure. No identifiers (patients, physicians, or hospitals) will be submitted to CDC for inclusion in any analytic data file. Only aggregate data will be reported and published. The protocol of this study has been approved by the IRBs of the \_\_\_ Cancer Registry and other participating institutions, and all study procedures and materials have been carefully reviewed to ensure complete compliance with HIPAA regulations.

Many patients with cancer welcome the chance to participate in a study that might help others. However, we will make it clear to your patient that he/she is under no obligation to participate in this study, that participation will not affect her care or treatment in any way, and that he/she may withdraw her consent to participate in this study at any time. If your patient declines to participate, we will respect the decision and will not attempt to contact him/her again.

Thank you for your support of this important study.

Sincerely yours,

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*Name of Cancer Registry, Principal Investigator*

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*Name of Cancer Registry, Study Coordinator*

**CICC Study**

PHYSICIAN NOTIFICATION FORM

Date of Notification: *Date*

PHYSICIAN NAME: Dr. «Physician First Name» «Physician Last Name»

PATIENT NAME & DOB: «First Name» «Last Name» DOB: «Date of Birth»

The above-named patient was identified through the *Name of Cancer Registry* as someone who was recently diagnosed with «Diagnosis» and is eligible to participate in the CICC Study.

We plan to contact this patient about the CICC Study within 2 weeks. Please check the appropriate box below and return this form by mail or confidential fax (see the number below) if a specific medical condition precludes participation by this patient, including but not limited to the following:

- Patient has NOT been informed of her cancer diagnosis
- Mental illness or altered mental status
- Severe physical debilitation
- Inability to speak and understand English or Spanish
- Other \_\_\_\_\_

We will contact your patient if we do NOT hear from you within two weeks.

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date

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PLEASE FAX TO: (XXX) XXX-XXXX

OR MAIL TO:

CICC Study  
*Study coordinator name and address*

FOR QUESTIONS CALL: (XXX) XXX-XXX