MAMMOGRAFIE-SCREENING
BEIDER BASEL

Please complete the form and TAKE IT WITH YOU to your appointment – **do not** return

Health questionnaire

Personal details (*mandatory fields)	Your reference no.
Last name	Daytime tel. no.*
First name	Mobile no.
Address	E-mail
Postcode, town/city	Health insurance provider*
Date of birth	OASI (AHV) no.

The result of the examination will be passed on to you and your **gynaecologist** in writing within 8 working days.

Please provide the name of your gynaecologist

Last name, first name

Postcode, town/city

Please also send the result to my family doctor (GP)

Last name, first name

Postcode, town/city

IMPORTANT – informed consent

With my signature, I hereby

- confirm that I have been informed about the principle of screening and early detection, its benefits and its limitations.
- confirm that I understand that this examination will be invoiced at a fixed amount with no excess and that a deductible of no more than CHF 20 will be charged, and that I will therefore not receive an automatic invoice copy. If I would like to receive a copy, I will contact the programme centre.
- consent to the transmission of my mammogram images previously taken and stored to the responsible physician at the Radiology Institute, as well as the accredited radiologists.
- consent to the exchange of my medical and personal data (hereinafter "data") between the professionals involved in the screening process, both by post and encrypted e-mail, as well as the collection and storage of my data by the Basel Cancer League (hereinafter "Cancer League"), to the extent that this is absolutely necessary for the implementation of the mammogram screening programme and the assurance of its quality; this data will be treated confidentially.
- consent to the exchange of information between the physicians designated by me and the Cancer League's department for prevention and early detection, to the extent that this is absolutely necessary for the implementation of the mammogram screening programme and the assurance of its quality.
- acknowledge that my participation in the mammogram screening programme will result any personal breast cancer diagnosis being reported to the Basel cancer registry.
- consent to the reporting of a minimum set of data (surname, first name, date of birth and address) by the Cancer League to the cantonal cancer registry in the event of a normal result for quality assurance purposes, and to the collection of my personal diagnostic data between two examinations.
- acknowledge that my anonymised data may be used for statistical purposes and to improve the quality of the programme.
- consent to the forwarding of my file to the official screening programme of my new canton of residence in the event of relocation.
- consent to the transmission of results of screening-relevant follow-up examinations to the Cancer League for the quality assurance of the mammogram screening programme.
- confirm that I have been informed in detail about the use, disclosure and storage of my data; I have the right to view, correct and object to the use of my data at any time.

Place, date _____ **Signature** _____

Mammogram Screening Programme Basel-Stadt • A programme by the Basel Cancer League • Petersplatz 12 • 4051 Basel Tel. 061 319 91 70 • screening@klbb.ch • www.screening-programme.ch

– PTO –

Why are we asking questions about your health? The information you provide in this questionnaire is important for the two radiologists who will independently assess your mammogram images.

I've already completed this questionnaire once. Do I have to complete it again?
YES, because some of your information may have changed since your last mammogram.

1. Have you ever had a mammogram?	yes no
If so, when?	Date: Name of the institution:
If so, why?	Screening Problems with my breasts Other reasons Don't know

2. Are you currently undergoing hormone therapy?	no yes, for_____ years now
Have you undergone hormone therapy in the past?	no, never yes, stopped _____ years ago, Duration of therapy_____ years

3. Has your mother, sister or daughter ever developed breast cancer?	no		yes	
If so, how old were they at the time of diagnosis?	**Your mother**	**Your sister**	**Your daughter**	
50 years or older				
Younger than 50				
Don't know				

4. Are you currently experiencing any breast discomfort?	no	yes
If so:	**Right breast**	**Left breast**
Pain		
Nipple discharge		
Lumps		
Other conditions (please provide details)		

5. Have you ever had breast surgery?	no		yes	
If so:	**Right breast**	**Left breast**	**Brief description**	**Year**
Benign condition (cyst, fibroma, etc.)				
Breast cancer				
Breast augmentation and/or reduction				
Don't know				
Other (please provide details):				

Information checked by the radiology clinic (signature):