

Modify sections of the form below in bold, underlined, and in [] square brackets to meet your program's name and provisions

Consent Form and Information for Oral Cancer Screening Program
_____ **Health Department**

Oral cancer screening is a check-up of your entire mouth (which is known as the oral cavity), and your throat and the back of your mouth (known as the oropharynx). Oral screening can find sores or lumps that are cancer or find abnormal areas that can turn into cancer.

Smoking and drinking alcohol cause most cancers in the mouth. **You can prevent oral cancer by not smoking and by not drinking heavily.**

If an abnormal looking area or a lump is found during the cancer screening, the Oral Cancer Screening Program will send you to a specialist to take a biopsy. A *biopsy* is a small sample of tissue from your mouth. This tissue sample is sent to a laboratory to see if it is cancer. Also, the screener may find an abnormal looking area and may want to take a sample of the area with a small brush during the exam today. This is called a *brush biopsy*. If the brush biopsy is abnormal, you will be sent to a specialist for a biopsy. The Program will explain the tests and results to you.

Please read and sign this Consent for Screening:

- I understand that this screening is to check my mouth for cancer. It is not meant to find other problems with my teeth and gums.
- I know that I am responsible for following any recommendations made for follow-up exams or tests. I understand that this screening is not complete (for example, no X-rays will be taken). This screening does not take the place of any exam that I have had in the past or will have in the future.
- I understand that this screening may not find every oral or pharyngeal cancer that I may have.
- I understand that the _____ Health **Department [will pay for future visits, tests, and procedures to treat cancer if I am eligible for these services to the extent of available funds. Eligibility is based on my family income and whether I have health insurance.] OR [I understand that if I am found to need more tests or treatment, the _____ Health Department will not be able to pay for these tests and treatment; doctors or hospital may bill me for further services.]**
- The information I give and the results of my oral screening (and brush biopsy, if one is done) will be kept by the _____ Health Department cancer program, **[add any other local contractors]**, and the Maryland Department of Health and Mental Hygiene and its data contractor. It will be used for statistical, clinical, and program management purposes only. I may inspect, amend, and correct the information on my records. Information will not be disclosed again to others except as allowed or required by Maryland or Federal law.
- I understand that the results of a positive cancer screening will be shared with my medical doctor or dentist, if I list one on the next page.

I have read the above statements and agree to them.

_____ (Date) _____ (Name)

_____ (Signature)

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Please read and sign this Consent for Brush Biopsy, if the Examiner requests a Brush Biopsy:

I understand that I was screened for oral cancer. The examiner saw an area in my mouth that was not normal. To see if this area is possibly cancer, the Oral Cancer Screening Program wants to take a brush biopsy of the area. I understand that there may be a little pain or bleeding when the brush biopsy is taken. The brush biopsy will be sent to a laboratory that will look to see if there is cancer. The lab will send the results back to the Oral Cancer Screening Program. The Program will then notify me about the results of the brush biopsy test. The Program will give me recommendations of what I should do after that.

I hereby give my permission to

_____ to take a

brush biopsy of _____.

_____ (Date) _____ (Name)

_____ (Signature)