

OPTING OUT OF SCREENING PROGRAM SERVICES

Why is screening for cancer important?

- Each year, more than 6,000 people in Saskatchewan are diagnosed with cancer. Many of these cancers can be prevented.
- Regular screening for breast, cervical and colorectal cancer can help detect changes before you have symptoms. Finding cancer early often allows for more treatment options and a better chance of recovery.

How do the screening programs get my information?

- The Saskatchewan Cancer Agency operates screening programs under The Cancer Agency Act.
- We receive information about Saskatchewan residents who can take part in these programs.
- If you are eligible to participate in screening services, you will be automatically enrolled. You will receive invitation letters sent to your mailing address.
- If you do not want to participate, you can opt out of the screening programs.

What are the benefits of the screening programs?

- We organize screening programs and mail reminders when you are due for screening.
- We mail out screening tests you can do at home and offer in-person breast screening (mammograms).
- We work with your health-care provider to make sure you get the right follow-up if you have abnormal results.

Can I opt out of screening program services?

- Yes. You can opt out of screening program services at any time.
- Call us **toll-free at 1-855-292-2202** or complete the attached form and send it to us by **mail, fax or email** using the contact information on the bottom of the form.

What happens after I opt out?

- You and your health-care provider will be responsible for all screening and follow-up.
- You will no longer receive any information from the screening program(s) you've opted out of.
- We will not track your follow up or notify you or your health-care provider of abnormal, unsatisfactory or diagnostic test results related to the screening program(s) you've opted out of.

How to rejoin the program

If you want to rejoin a screening program, call us toll-free at **1-855-292-2202** or email **ED.Coordinator@saskcancer.ca**. Please include your full name, health card number, date of birth and a phone number where we can reach you.

If you received this document by mistake, call us toll-free at **1-855-292-2202** or email **ED.Coordinator@saskcancer.ca**.

SCREENING PROGRAM OPT-OUT FORM

Discussion with your health-care provider is strongly recommended prior to opting out of screening programs. Only people of eligible screening age for each screening program will be opted out.

Please check the appropriate program(s):

<input type="checkbox"/> ColonCheck Upon receiving this signed opt-out form, ColonCheck will: <ul style="list-style-type: none"> no longer send you reminder letters or test kits no longer track any future follow up of abnormal, unsatisfactory or diagnostic test results related to screening for colorectal cancer <p>Future screening for colorectal cancer and any necessary follow-up will be the sole responsibility of you and your health-care provider.</p>	<input type="checkbox"/> CervixCheck Upon receiving this signed opt-out form, CervixCheck will: <ul style="list-style-type: none"> no longer send you reminder letters no longer track any future follow up of abnormal, unsatisfactory or diagnostic test results related to screening for cervical cancer <p>Future screening for cervical cancer and any necessary follow-up will be the sole responsibility of you and your health-care provider.</p>	<input type="checkbox"/> BreastCheck Upon receiving this signed opt-out form, BreastCheck will: <ul style="list-style-type: none"> no longer send you reminder letters no longer track any future follow up of abnormal, unsatisfactory or diagnostic test results related to screening for breast cancer <p>Future screening for breast cancer and any necessary follow-up will be the sole responsibility of you and your health-care provider.</p>
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Personal Information		
Last Name:	First and Middle Name:	
Address:		
City:	Province:	Postal Code:
Date of Birth: (required for identity confirmation)	Health Card Number: (required for identity confirmation)	
Phone Number:		

Authorization	
By signing this form, you confirm that you have read and understood the information on page 1, that the details you provided are true and correct, and that you accept the terms and conditions described here.	
Signature:	Date:
<input type="checkbox"/> I am the Substitute Health-Care Decision Maker for the above-named individual and am authorized to make decisions regarding their health care and personal health information. I consent to the screening programs calling to confirm details of this form if needed.	
Substitute Health-Care Decision Maker Name:	
Substitute Health-Care Decision Maker Phone Number:	

Mail, fax or email this completed form to:

Screening Programs
 101 – 4545 Parliament Avenue
 Regina, Saskatchewan S4W 0G3
 Fax: (639) 625-2199
 Email: ED.Coordinator@saskcancer.ca