Cancer and Tobacco Prevention Program 1401 Rockville Pike, 2nd & 4th Floors, Rockville, MD 20852

Colonoscopy Referral — **Main 240-777-1222** — **Fax 240-777-1261**

Breast/Cervical Referral — **Main 240-777-1750** — **Fax 240-777-4819**

Are you interested in Breast/Cervical Cancer Screening and /or Colon Cancer Screening?

□ **Breast and Cervical** □ **Colon** □**Both** □**Patient Navagation**

Patient Information

Date of Referral: ____________________

Last Name: First Name: MI: ____________

Street Address: ____

City:____ ______________________ State ________________ Zip ____________________

Telephone Work: ( ) ________ Home Phone: ______________________ Alt. Phone: ____________

Date of Birth: / / County: ____________________________

Annual Family Income: Family Size (include self):

Gender:
- □Male
- □Female

Race: ***(check as many as apply)***
- □White/Caucasian
- □ Asian
- □Other
- □Black/African American
- □Amer. Indian/Alaskan Native
- □Native Hawaiian/Pacific Islander

Education:
- □ No high school
- □ Some high school
- □ High school graduate/GED
- □ Greater than high school
- □ Unkown

Country of Birth: ________________

Ethnicity:
- □ Black Latina/ Hispanic □White Latina/Hispanic
- □ Non-Hispanic

Primary Language:
- □ English □ Other:____________________
- □ Spanish □ Interpreter needed

Do you have health insurance? □Yes □No □Don't Know

If yes, what type: □Medicare ☐Medicaid ☐Private ☐Other

Primary or Requesting Provider

Name: (Last, First, MI)	Institution/Group Name:
Phone Number: ( )	Facsimile/Data Number: ( )

Reason for Referral: (Please check those that apply)

☐ Colonoscopy for colorectal cancer screening

☐ Flexible Sigmoidscopy for colorectal cancer screening

Indications: (Age 50+ or increased risk)

☐ Age 50 and over

☐ Personal history of colon polyps or colorectal cancer

☐ Personal history of inflammatory bowel disease over 8 years

☐ Family history of colon polyps or colorectal cancer

☐ (see Maryland DHMH Colorectal Cancer Screening Guidelines)

Has the patient been screened for colorectal cancer before?

□ Yes □ No □ Don't Know

If "Yes", what was the test, date of most recent test?

□ FOBT:________ □ Colonoscopy:__________________

□ Flexible Sig:_______ □ Bariuma Enema:________________

Brief History, Diagnosis, and Tests Results: ______________

Reason for Referral: (Please check those that apply)

□ **Breast Cancer Screening**
- □ Age 40-49
- □ 50 and over

□ CBE □MAMMO

□ **Cervical Cancer Screening**
- □ Age 40-49
- □ 50 and over
- □ PAP Test □PAP/HPV Test

What was the date of last clinical breast exam?__________

What was the date of last mammogram?_______________

What was the date of last PAP test ?__________________

Describe any breast and or cervical concerns________

Signature: (Individual completing this form)

Referral is not a guarantee of that the Cancer and Tobacco Program will pay for any future tests and procedures. Funds available to help low-income, uninsured or underinsured eligible Montgomery county residents.

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