[PROGRAM NAME/HEALTH DEPARTMENT]

**Cancer Screening and Patient Navigation Referral Form**

Complete the information below to refer patients to the **[Program/Health Department Name] Cancer Screening Patient Navigation Services**. Patient Navigators will assist patients in completing their cancer screening process and provide the following services:

* Address barriers to assist patients in completing their appointments and recommended follow-up;
* Ensure patients receive and understand their results;
* Follow-up to provide support to patients for additional work-up for diagnosis and/or treatment.

**Please fax or e-mail completed form to [Fax #] or [E-mail Address].**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION**: | | **DATE OF REFERRAL:** \_\_\_ / \_\_\_ /\_\_\_ | | | | |
| Name: (Last, First, MI) | | | | | | Date of Birth:  \_\_\_ / \_\_\_ /\_\_\_ |
| Primary Phone Number:  ( ) - | | Other Phone Number / Contact Information: | | | | |
| Insurance Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **PRIMARY OR REQUESTING PROVIDER INFORMATION:** | | | | | | |
| Name (Last, First, MI) | | | | Practice: | | |
| Street Address: | | | | | Suite/Office #: | |
| City, State, Zip Code: | | | | | | |
| Phone #: ( ) -  Fax# : ( ) - | | | E-Mail: | | | |
| **REASON FOR REFERRAL:** (Check all that apply.) | | | | | | |
| ☐ Patient Navigation for Breast Cancer Screening  ☐ Patient Navigation Cervical Cancer Screening  ☐ Patient Navigation for Colorectal Cancer Screening  ☐ Tobacco Cessation Program  ☐ [Enter Other Referral Reasons Here]  ☐ Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **REFERRAL STATUS:** | | | | | | |
| Client agrees to be notified by [Program/Health Department] :☐ **Yes** ☐ **No** | Pre-Screening/Screening Visit Scheduled:  \_\_\_ / \_\_\_ /\_\_\_ | | | | | |

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[PROGRAM NAME/HEALTH DEPARTMENT] ● Phone: [Phone #] ● Fax: [Fax #]