[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 #]