C-STEP use only:
CHW: _____
Event: _____

TEXAS A&M PHYSICIANS
TEXAS A&M HEALTH SCIENCE CENTER

Please complete form
Send most recent PHI
Physician Signature required

Texas A&M Physicians • 2900 E 29th Street • Bryan • Texas • 77802 • 979 776 8440 (P) • 979 776 6905 (F)

Angie Choate - 979 436 0443
Rebecca Martinez - 979 436 0453

COLONOSCOPY Referral Form

Self-Referral? Yes / No

Date:_____

Referring Physician / Organization: _____

Phone #:_____

Clinic:_____

Fax:_____

Address:_____ City:_____

County:_____ State:_____ Zip Code:_____

Patient Name: _____

DOB:_____

Mailing Address:_____

Phone #1:_____ ☐ Home ☐ Cell

City:_____ County:_____ State:_____

Phone #2:_____ ☐ Home ☐ Cell

Zip Code:_____ Gender: Male / Female (Please Circle)

Preferred Language:_____

Patient Allergies:_____

Service Required (Check all that apply): ☐ Screening Colonoscopy ☐ FIT Test

Reason for Referral (Check all that apply): ☐ Positive FIT/FOBT ☐ Black stools/Melena ☐ Diarrhea

☐ Anemia ☐ Bleeding ☐ Abdominal Pain ☐ Constipation Other:_____

Family History of Polyps/Colorectal Cancer: ☐ Father ☐ Mother ☐ Sibling ☐ Grandparent

Comments: _____

Is this patient insured? Yes / No

Does the patient have Medicare? Yes / No

Provider: _____

Policy Group #:_____

Policy ID #:_____

PCCM/PCP:_____

Does the patient wish to determine financial assistance eligibility? Yes / No

_____ _____

Provider Signature (if applicable) Date