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

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Yanelly Palomo - 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 on ID: _____

DOB (MM/DD/YYYY):_____

Preferred Name:_____

Phone #1:_____ ☐ Home ☐ Cell

Mailing Address:_____

Phone #2:_____ ☐ Home ☐ Cell

City:_____ County:_____ State:_____

Preferred Language:_____

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

Patient Allergies:_____

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

Reason for Referral (Check all that apply): ☐ Screening ☐ 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