FIT TEST KIT NUMBER:
_____

TEXAS A&M UNIVERSITY HEALTH

Please complete form
Send most recent PHI
Physician Signature required

Texas A&M Health Family Care• 2900 E 29th Street • Bryan • Texas • 77802 • 979 776 8440 (P) • 877 601 5854 (F)

Colorectal / Liver Screening - 979 436 0443

Referral Form

Self-Referral? □ **YES** □ **No** Date:_____

Referring Physician / Organization: _____ Phone: _____

Clinic: _____ Fax: _____

Address: _____ City: _____

County: _____ 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:_____

Colorectal Screening Service Required (Check all that apply)☐ Colonoscopy ☐ FIT Test ***Previously Screened*** **(FIT):** □ Yes □ No

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: _____

Liver Screening Service Required: □ Hep C Antibody Screening

Family History: _____
Comments: _____

_____ _____
Provider Signature or Authorized Representative Date