Karmanos
CANCER INSTITUTE

Colorectal Cancer Screening Referral Form

Please fill out entire document to avoid delays in scheduling. Patients will be called within 72 hrs. to confirm a date and time. For questions, please call **Procedure RNs at 248-538-3064**.

Please attach the Patient Demographics and/or Face sheet. If not available, please complete the information below.

Patient Name_____ Colorectal Screening Location: **Karmanos**

DOB_____ Gender: Female ☐ Male ☐

Patient's Home Phone_____ Patient's Cell/Alternate Phone _____

Insurance: _____ Insurance Auth # (if needed) _____

Referring Provider_____ Referring Provider NPI #_____

Referring Provider Phone #_____ Referring Provider Fax #_____

Please certify the below:

- The patient is between the ages of **45-75**- The patient may have a copay/deductible if the insurance is not adhering to the updated guidelines.
- The patient is asymptomatic for colon cancer (no symptoms such as bleeding, cramping, gastrointestinal symptoms, unexplained weight loss, etc.)
- Does Patient have any of the below conditions? If they have 3 or more of these conditions, they are *NOT* a candidate

  ☐ Asthma ☐ COPD ☐ Hypertension ☐ Diabetes ☐ BMI >40 ☐ Wear Oxygen

  ☐ Does NOT have clearance to stop blood thinners temporarily

Please send the patient's Script, Last Clinical Note and Medication List with this order form

Request Type: ☐ **NEW** ☐ **REVISION** **Urgency:** ☐ **URGENT (ASAP)** ☐ **Routine**

Requested Surgeon: ☐ First Available Physician ☐ Other: _____

Requested Date: ☐ Earliest Available Date ☐ Other: _____

Please Select the Procedure Type

☐ **Colonoscopy Colorectal Cancer Screening**
☐ **Esophagogastroduodenoscopy EGD**
☐ **Colonoscopy and EGD**
☐ **Sigmoidoscopy**

Please Fax this order to Karmanos at (313)-576-9827
(phone# 1-800-527-6266) E-mail: screening@karmanos.org
We will contact your patient to schedule the exam