

ACT Colorectal Screening Project
Referral Direct to Colonoscopy for Patients at Increased Risk
FAX 713-794-1951 or scan and email to rjkingston@mdanderson.org

Referring clinic _____

Date of Referral _____

Physician _____

Indications for referral. Please check all applicable:

- personal history of colorectal cancer or adenomatous polyps
- personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- strong family history of colorectal cancer or polyps
- known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC)

Patient Name _____

Date of Birth _____

Address _____

City, State, Zip Code _____

Phone _____

Alt Phone _____

Confidentiality Notice

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