THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

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_____

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