COLONOSCOPY SCREENING ACCESS PROGRAM

PROVIDED BY: Moffitt Cancer Center

REQUEST FORM

Referral Date: _____ (request valid for 90 days from referral date)

Patient Name: _____ DOB: _____

Patient Address: _____

Zip Code: _____ Patient Phone Number: _____

Preferred Language: _____ Marital Status: _____

Name of Referring Clinic: _____

Name of Referring Provider: _____

Clinic or Provider Phone Number: _____

To qualify the patient must meet ALL of the following criteria:

- ☐ Must be 45 years of age or older, AND
- ☐ Must have no health insurance, AND
- ☐ Must not have had a screening colonoscopy within the last 10 years, AND
- ☐ Must not have any acute symptoms

If the patient meets ALL of the above criteria, please follow the instructions below and inform your patient of the expectations for the screening procedure.

1. Fax this form, recent clinic notes and patient demographics to **813-745-4976.**
2. Once the faxed information has been reviewed and approved, our team will contact the patient to schedule the procedure. The patient must be responsible for **returning phone calls within 48 hours** and arranging their appointment.
3. A prescribed prep is required for this procedure. The estimated cost is $25. The patient must **exactly** follow all instructions for the prep.
4. Because a sedative is used during this procedure, **the patient will need to arrange for someone to bring them to the appointment, stay with them and take them home after the procedure.**

Thank you for referring our patient to Moffitt Cancer Center.

Please email any questions to MPOWER@Moffitt.org.

Patient, please bring this request form with you to your appointment. *Por favor traigan este formulario a su cita.*

1-888-MOFFITT (1-888-663-3488) www.Moffitt.org

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