Kentucky CancerLink
PATIENT REFERRAL FORM

REFERRAL INFORMATION			
Date:	Organization:	Referring Navigator:	Phone #: ( )

PATIENT INFORMATION			
Patient's Last Name: First: Middle:		Birth date: / / Age:	Sex ❑ M ❑ F
❑ African American/Black ❑ Hispanic/Latino ❑ Asian ❑ Caucasian/White ❑ Other:____________	Social Security #: ____-____-____	Primary Phone #: ❑Hm ❑Wk ❑Cell ( )	
Street Address:	Email Address:	Alternate phone #: ❑Hm ❑Wk ❑Cell ( )	
City, State, ZIP Code:		OK to leave messages identifying ourselves as KY CancerLink? ❑ Yes ❑ No	
County:	Employment Status:	Primary Language: ❑English ❑Spanish ❑Other	
Date of Cancer Diagnosis (Month/Year):	Cancer Type:	Second Diagnosis: Y / N	Stage of Cancer:
Insurance (All that apply): ❑Private ❑Medicare ❑Medicaid ❑Uninsured	# in Household:	Annual Household Income: $	

❑ Patient's Consent (HIPAA): Patient understands the HIPAA policy and agrees with the disclosure of this information to Kentucky CancerLink for the purposes of applicable follow up. Kentucky CancerLink is a private organization and does not share personal health information.

Patient's Signature (if applicable):______________________ Date: ______________

SELECT REQUIRED FOLLOW UP (CHECK ALL THE APPLY)

❑Transportation
- ❑ Gas card
- ❑ Other____________

❑Supplies
- ❑Wig
- ❑Bra
- ❑Breast Form
- ❑Lymphedema Sleeve/Glove/Ga
- ❑Other: ____________

❑Financial Assistance
❑Support Group
❑Educational Information
❑Other Resources:

- ❑ CBE (Breast Exam)
- ❑ Mammogram
- ❑ MRI
- ❑ Ultrasound
- ❑ Pap
- ❑ Colon Cancer Screening (Fayette County)

Mammogram Information:
- ❑ Screening Mammogram Needed
- ❑ Diagnostic Mammogram Needed
- ❑ Implants (Yes/No)
- ❑ Allergic to Latex (Yes/No)
- ❑ Breast Problems (Yes/No)
- ❑ Smoker (Yes/No)

Has person had a mammogram before?____________
Date of last mammogram____________
Facility for last mammogram____________

EMERGENCY CONTACT INFORMATION			
Name of local friend or relative:	Relationship to patient:	Primary phone #: ❑Hm ❑Wk ❑Cell ( )	Alternate phone #: ❑Hm ❑Wk ❑Cell ( )
OK to leave messages identifying ourselves as KY CancerLink? ❑ Yes ❑ No			

PHYSICIAN INFORMATION		
Physician's Name or Other Physician:	Primary phone #: ( )	Fax phone #: ( )
Street Address	City State	Facility Location:

OTHER INFORMATION
Comments:

Please FAX form to Kentucky CancerLink at 859-368-8418 **Revised 6/3/14**
Questions? Please call 859-309-1700