Kentucky CancerLink
PATIENT REFERRAL FORM

Please complete form as fully as possible

2425 REGENCY ROAD, SUITE B
LEXINGTON, KY 40503
PHONE # 859-309-1700
FAX# 859-368-8418

REFERRAL INFORMATION

Date:	Organization	Referring Navigator	Phone #: ( )

PATIENT INFORMATION

Last Name: **First Name:** **MI:**

Address:

City: **State:** **Zip code:** **County:**

Email:

Race: □ African American/Black □ Caucasian/White □ Asian □ Native Hawaiian/Other Pacific Islander
□ American Indian/Alaskan Native □ Asian/Pacific Islander

Hispanic/Latino Origin □ Yes □ No **Sex:** □ M □ F

Social Security Number: **Birth Date:** (MM/DD/YYYY)

Employment Status:
□ Employed □ Unemployed □ Disabled □ FMLA □ Retired
□ Laid off □ Leave of Absence □ Drawing Unemployment □ Student □ Homemaker

Language Note: □ English Speaking □ Spanish Speaking Only □ Other Language Spoken:

Home Phone: **Cell Phone:** **Work Phone:**

Okay to Leave Messages on Phone: □ Yes □ No

Emergency Contact Name: **Phone:** **Relationship:**

Primary Insurance: □ Medicaid □ Medicare □ VA □ Private □ Uninsured
Secondary Insurance:

Discussed HIPPA Compliance: □ Yes □ No **Number In Household:** **Annual Household Income:**

Smoker? □ Yes □ Never □ Previous Smoker □ Unknown □ Declined
If yes, interested in quitting? □ Yes □ No

Educational Level: □ Less than High School □ GED or High School □ Some College □ College Degree □ Declined

INFORMATION REQUIRED ABOUT THE CANCER DIAGNOSIS (IF APPLICABLE)

Date of Cancer Diagnosis (MM/YYYY): _____ **Cancer Type:**_____ **Second Diagnosis Yes/No**

Current Stage:_____ **Treatment Facility:**_____

HOW CAN WE HELP YOUR PATIENT?

Patient Services Referral

❑Transportation Assistance
❑Supplies
- ❑Wig/Headwear
- ❑Bra
- ❑Prosthesis/Breast Form
- ❑Lymphedema Sleeve/Glove/Gauntlet
- ❑Other: _____

❑Support Group
❑Educational Information
❑Other:

Procedure Referral

BREAST:
- □ CBE (Breast Exam)
- □ MRI
- □ Ultrasound

Mammogram
- □ Diagnostic Mammogram
- □ Screening Mammogram

Previous mammogram?_____
Date of last mammogram?_____
Facility for last mammogram? _____

CERVICAL:
- □ Pap Test
- □ Colposcopy

COLON:
- □ OC-Light FIT Kit
- □ Colonoscopy
- □ Stool DNA (Cologuard)

LUNG:
- □ Low-Dose CT Scan

PHYSICIAN INFORMATION

Physician's Name or Other Physician:	Primary phone #	Fax#

Street Address: City: State: Facility Name and Location: