ACCION
Against Colorectal Cancer
In Our Neighborhoods

PATIENT CLOSURE

Name _____

Diagnosis_____ FIT ID _____Participant ID_____

Date Service Initiated_____ Last Date of Service_____

      Lost to follow-up   Deceased   Completed treatment   Termination

SUMMARY

PCP   _____

Referrals   _____

Medicaid/SSI   _____

Medicare   _____

American Cancer   _____
Society

TANF   _____

Housing   _____

Others   _____

Certified Letter Sent   Date Letter Sent: _____

Patient Navigator _____   Date_____

Supervisor_____   Date_____