Primary Care Provider/Clinic CRCS Form

Colorectal Cancer Screening Report Form

In the chart below, please fill in the colorectal cancer screening information for a [type of screening] done in the past 15 months for the following patient:

Name _____ Date of Birth _____

Designate type of test	*Date of test*	*Specify reason for test*
Test (FOBT, FIT, COL)	**Date** (mm/dd/yyyy)	**Reason** (screening or diagnostic)

Fecal Occult Blood Test (FOBT), Fecal Immunochemical Test (FIT), Colonoscopy (COL)

☐ No colorectal cancer screening tests found in the medical record

☐ Not one of our patients

Other _____

If you have any questions, please feel free to call the Family CARE Project office at xxx-xxx-xxxx or toll-free at xxx-xxx-xxxx or email us at EMAIL@ADDRESS.

Please complete and return this form in the postage-paid envelope or to:

NAME
ADDRESS

Thank you for your assistance with the Family CARE Project!