

Utah Department of Health
Bureau of Health Promotion
Utah Cancer Control Program (UCCP)
Box 142107
Salt Lake City, Utah 84114-2107
Telephone: (801) 538-6736 or 1-800-717-1811 **Fax: (801) 538-9495**

PRIMARY CARE PROVIDER REFERRAL AGREEMENT

I, _____ agree to be a referring primary care provider for the Utah Cancer Control Program's colon cancer screening program. By agreeing to be a referring provider, I commit to the following actions:

1. Complete, with the patient, the enrollment form and consent.
2. Review, with the patient, the qualifications of the program understanding that the patient may not qualify or the program may not be able to provide the screening due funding limitations.
3. Submit the referral and consent forms to the program Clinical Coordinator by fax (801)538-9495 and work with the Coordinator in a timely manner if they have any follow-up questions or concerns.
4. Agree to work with the patient for any follow-up appropriate for my specialty and/or licensure after the colonoscopy.

Signature

Date

License number

Facility

Address

City, State, Zip

Phone

Fax

E-mail