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