Health Systems Change Clinic Patient Navigation Card for Abnormal Colon Screening

PROVIDER NOTE: **Based on navigation services provided, appropriate information must be completed.**

Medical Record #: ____________________________

Client Date of Birth: _____/_____/_____

Gender: ❑Female ❑Male

Client Zip Code: __________

Is client Hispanic/Latina(o) origin? ❑Yes ❑No ❑Unknown

What is the client's race?: ❑American Indian/Alaska Native Tribe ___________ ❑Black/African American ❑Mexican American ❑White ❑Asian ❑Pacific Islander/Native Hawaiian ❑Unknown ❑Other__________________

Does client have insurance?: ❑Yes ❑No

If yes, is it: ❑Medicare (for people 65+) ❑Part A and B ❑Part A only ❑Medicaid (full coverage for self) ❑Healthcare Insurance Marketplace ❑Private/Employer Insurance

Abnormal Colon Screening

Navigation Guidelines: Women and Men 45 to 74

Screening Test Date for positive FOBT/FIT: ___/___/___

❑FOBT ❑FIT ❑iFOBT

Diagnostic Test Provided:

❑Colonoscopy

Final Diagnosis:

❑Normal/Negative ❑Polyp No HG Dysplasia ❑Polyp w/HG Dysplasia ❑Cancer

Final Diagnosis Date: ___/___/___

Treatment Start Date: ___/___/___

Structural Barrier Support Assessed and Provided:

❑Transportation ❑Interpretation ❑1:1 Accompaniment ❑Child/Elder Care ❑Extended Hours ❑1:1 Education ❑Partnership Referral ❑Partnership Payment ❑Prep Paid ❑Sample Prep Given

CONTACT #1: _____/_____/_____

By: ______________________________

NOTES:

CONTACT #2: _____/_____/_____

By: ______________________________

NOTES:

____

Clinician Name ***(PRINT** full name-do not abbreviate)*

____

Clinic Name ***(PRINT** full name-do not abbreviate)*

REMINDER:
Please send the CRC Referral Form with the Client

Central Office Use Only:

❑**Approved for Data Entry** ______

Send completed form to:

Fax: 402-471-0913

Email: dhhs.EWM@nebraska.gov