Cancer Treatment Services
Jerry Marquette Radiation Oncology Center
and Tatman Cancer Center
Coffeyville Regional Medical Center
www.crmcinc.org

2017 Fecal Immunochemical Kit (FIT) Consent Form

Patient Information Card

Yes, I want to be screened for colorectal cancer. I have received education about this screening and am taking a Fecal Immunochemical Test kit home to do the screening. After completing the kit, I will send it in the envelope provided for analysis.

Have you been screened for colon cancer before? _____ No, never. _____ Yes, within the last year.
_____ I don't know. _____ Yes, more than a year ago

Name: _____

Address:_____
Street/Apt. # City, State Zip

Telephone Number # with area code _____

Birth Date: _____ Sex: _____Male _____Female
Month/Day/Year

Physician: _____ Address:_____

Ethnic Background: _____
(optional): _____ African American _____ Asian _____ Hispanic
_____ Native American _____ Caucasian _____ Other
_____ Pacific Islander

If my test results come back positive, please send the results to my physician listed above.
__Yes ___ No

If I do not have a primary care physician, may we contact you with a referral to a CRMC primary care physician?
__Yes ___ No

_____
Patient Printed Name

_____ _____
Patient Signature Date