Certification of Need
Screening for Colorectal Cancer
for Individuals Under Age 50

Client's Name:
Address:
Date of Birth:
Phone #:

Please check all that apply:

- ❑ Has a family history of colorectal cancer or adenomatous polyps in a first-degree relative < age 60 years or in 2 or more first-degree relatives at any age. *(Screening should begin at age 40 or 10 years before the youngest case in the immediate family.)*
- ❑ Has a family history of colorectal cancer or adenomatous polyps in a first-degree relative $\geq$ age 60 years or in 2 second-degree relatives with colorectal cancer. *(Screening should begin at age 40.)*
- ❑ Has a personal history of adenomatous polyp(s) or colon cancer.
- ❑ Has a personal history for $\geq$ 8 years of Crohn's Disease.
- ❑ Has a personal history for $\geq$ 8 years of Ulcerative Colitis.
- ❑ Has a documented hereditary syndrome (HNPCC, FAP, or AFAP).
- ❑ Other* List *all* signs/symptoms:____
  ____

* NOTE: Under the category "other" you *must* also submit additional documentation (i.e. copies of lab work, progress notes, radiology reports, etc.) to demonstrate that other possible causes of symptoms have been ruled out and to support your belief that there is reasonable justification to request a ***colorectal cancer screening*** at this time.

"I certify that even though this client is under the age of 50, I believe he/she is at increased risk for colorectal cancer for the reason(s) indicated above. Therefore, I am requesting a colorectal cancer screening colonoscopy through this program."

Physician's Signature: ____ Date: ___________

Physician's Name (please print): ____

Clinic Name: ____

Clinic Address: ____

You may fax a copy of this completed form to us to expedite the process; however please also mail the form with the original signature to the program. Keep a copy for your records.

Wyoming Colorectal Cancer Screening Program (WCCSP)
Wyoming Department of Health
6101 Yellowstone Road, Suite 510, Cheyenne, WY 82002
Phone #: 800-264-1296 Fax #: 307-777-3765

For WCCSP Office Use Only: Review Date: _____________ Request **Approved** _____ Request **Denied** _____

Reason(s) for Denial: ____
____

WCCSP Reviewer's Signature: ____

Reviewing Physician's Signature: ____