ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH & FAMILY SERVICES
ILLINOIS BREAST AND CERVICAL CANCER PROGRAM (IBCCP)

REQUEST FOR CLIENT TRANSFER

Date: _____

IBCCP Agency REQUESTING Transfer Initiates Form:

Name of Agency: _____

Agency staff person requesting transfer: _____

Agency staff person's e-mail address: _____

Agency phone number: _____ Agency fax number: _____

IBCCP Agency Where Client is Currently Active: _____

Name of Client Requesting to be transferred: _____

Cornerstone ID #: _____ Date of Birth: _____ Age: _____

IBCCP Agency TERMINATING Client:

Date Documentation Sent to the Requesting Agency: _____

Documentation Sent Via the following Route:

- ☐ Cornerstone SV06 Report (Procedure History Inquiry) ☐ Fax; ☐ Mail
- ☐ Two most current PA30 for both Breast and Cervical ☐ Fax; ☐ Mail
- ☐ Pertinent abnormal data necessary to continue services (list) ☐ Fax; ☐ Mail

_____
_____
_____
_____
_____

Verified by: _____, Nurse Clinical Patient Navigator Date: _____

**** Once the bottom section has been completed fax the form and supporting documents to the requesting (new) agency.**