



NEW PATIENT REFERRAL FORM

Records Required for Referral: (Please fax to 901.922.6701 with form)

Oncology DX or High Risk Assessment DX:

- Pathology Report
- Imaging Report
- Recent Office Notes
- Lab Report

Hematology DX:

- Lab Report
- Recent Office Notes

Physician Notes:

Diagnosis / Reason for Visit: _____

Appointment Preference: We will book an appointment with one of our specialists unless a specific provider is requested.



Requested Provider: _____

Urgency: Within 24 hours Within 48 hours Within 1 week Appointment Date: _____

Does this patient know why they are coming to West Cancer Center: Yes No Uncertain

*** Can West Cancer Center reach out to the patient directly to schedule their appointment:** Yes No

How would you like to be notified of the patient appointment date & time? Fax Email Phone

Patient Information:

Name: _____ **Date of Birth:** _____ **Female** **Male**

Address: _____

City / State: _____ **Zip:** _____ **SSN:** _____

Primary Phone: _____ **Secondary Phone:** _____

Does this patient have any communication, language, cultural, or ethnic needs? Yes No

If so, please describe: _____

Patient's Preferred Language: _____

Referring Physician Information:

Referring Physician & Office: _____

Address: _____

Contact Person: _____ **Contact Phone Number:** _____

Contact Email: _____ **Office Fax:** _____

Patient Insurance Information:

Primary: _____ **Secondary:** _____

Insured: _____ **Insured:** _____

ID Number: _____ **ID Number:** _____

Policy Holder SSN: _____ **Policy Holder SSN:** _____

Internal Notes

Appointment Notes:

Completed OL CB RFD Scheduled: _____ RFD Appointment: _____

Date: _____ Time: _____ Date: _____ Time: _____

Form of Submission: _____ Email _____ Fax _____ Phone

DX: Yes No

- Hematology
- Medical
- Radiology
- GYN
- Consult Only
- Refer & Treat
- Co-Management