WEST CANCER CENTER & RESEARCH INSTITUTE

Today's Date: _____

Please fax referral form and records to 901.922.6767.

For any questions, please contact **901.683.0055**.

NEW PATIENT REFERRAL FORM

Information Required with Form: ☐ Patient will bring ☐ Physician will send

Oncology DX:

☐Pathology Report ☐Imaging Report

☐Recent Office Notes ☐Lab Report

Hematology DX:

☐Lab Report

☐ Recent Office Notes

Physician Notes:

Diagnosis (Reason for Referral): _____

Urgency: ☐Within 24 Hours ☐Within 48 Hours ☐Within 1 Week ☐Date to Schedule: _____

Does this patient know why they are coming to West Clinic? ☐Yes ☐No ☐Uncertain

West Cancer Center will communicate all care to the patient, family, and/or caregiver.

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City/State: _____ Zip: _____ SSN: _____

Primary Phone: _____ Secondary Phone: _____ ☐ Male ☐ Female

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

If so, please describe: _____

_____

Patient's Preferred Language: _____

Referring Physician Information:

Referring Physician: _____ Telephone/Fax: _____

Address: _____

Contact Person: _____

Patient Insurance Information:

Primary: _____ Secondary: _____

Insured: _____ Insured: _____

ID Number: _____ ID Number: _____

Phone Number: _____ Phone Number: _____

Policy Holder SSN: _____ Policy Holder SSN: _____

_____

INTERNAL USE ONLY:

☐ Medical ☐ Consult Only

☐ Hematology ☐ Refer & Treat

☐ Radiology ☐ Co-Management

Date Records Sent: _____