

Date: _____

Patient Information

_____ Name	_____ Date of Birth	_____ Social Security
_____ Street Address	_____ City, State, Zip	
_____ Home Phone	_____ Cell Phone	
_____ Primary Insurance Provider	_____ ID Number	_____ Group Number
_____ Secondary Insurance Provider	_____ ID Number	_____ Group Number

Referring Physician Information

_____ Referring Physician Name	<input type="checkbox"/> I would like this patient to be seen at CCNW by Dr. _____
_____ Phone	<input type="checkbox"/> I would like this patient to be seen by the next available oncologist
_____ Fax	
_____ Office Contact Person	_____ Reason for Referral

Referring Physician Checklist

Along with this form, please provide us the following materials to ensure as smooth a transition as possible:

- Patient profile containing demographic and insurance information
- Copy of insurance cards (front and back) and referral if required
- All pathology reports and special tests (such as Her2Nu or an ER & PR report) and bone marrow biopsies/aspirations
- Recent labs, including tumor markers (CEA, PSA, ect.)
- Consultations and progress notes
- Operative reports, discharge summaries
- Chemo flow sheets, radiation summaries
- Actual films or disks (if films are not available on Stentor) and reports on all CXRs, CTs, MRIs, PETs, bone scans, EKGs, MUGAs, *-oscopies and other related tests

Please fax this referral form and the medical information listed in the above Referring Physician Checklist to (509) 252-9337. Thank you for your referral.