



CANCER CENTER

Today's Date \_\_\_\_\_

PLEASE SEND REFERRAL FORM AND RECORDS TO :

FAX: 901-722-0570

For any question, call 901-752-6131

### NEW PATIENT REFERRAL FORM

Diagnosis/Reason for Referral \_\_\_\_\_

Physician that you are referring to \_\_\_\_\_  No Preference

How soon would you like the patient to be seen: \_\_\_\_\_

Does the person know why they are coming to Baptist Cancer Center?  Yes  No  Unsure

Records required for referral:

Pathology (if applicable)  Most recent progress note  Most recent labs  Imaging

### PATIENT INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Secondary Phone # \_\_\_\_\_

DOB \_\_\_\_\_ SSN# \_\_\_\_\_

Sex  Male  Female

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

If so, please describe \_\_\_\_\_

Patient's preferred language \_\_\_\_\_

Does this patient use any assistive devices (wheelchair, walker etc.)?  Yes  No

If so, please describe \_\_\_\_\_

### REFERRING PHYSICIAN

Referring Physician \_\_\_\_\_

Address \_\_\_\_\_

Telephone/Fax \_\_\_\_\_ Contact \_\_\_\_\_

Is the referring physician the patient's primary care provider?  Yes  No

### PATIENT INSURANCE INFORMATION

Primary Ins. \_\_\_\_\_

Secondary Ins. \_\_\_\_\_

Insured \_\_\_\_\_

Insured \_\_\_\_\_

ID# \_\_\_\_\_

ID# \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_

SSN \_\_\_\_\_

Please complete all the blank fields and fax along with the required documents