Medical Oncology Patient Referral Form

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| **Patient Referral Coordinator: Phone: 208.625.4719 Fax: 208.625.4701** |
| **🞏 First Available Physician OR** | **🞏 Physician Preference:** |
|  |  |  |  |
| **Referring Office Information Required:** |
| Referring Physician: |  |  |  |
| Patient Name: |  |  |  |
| Home Phone: |  | Date of Birth: |  |
| Diagnosis: |  |  |  |
| Diagnosis Date: |  | Surgery Date: |  |
|  |  |  |  |
| **Please Include:**  | * **Demographics**
* **Progress Notes**
 | * **Pathology**
* **Imaging**
 | * **Labs**
 |
| ***• Please indicate the contact person at your office who can best assist with this referral:*** |
| Contact Person: |  | Date Referred to KCCS: |  |
| Direct Phone #: |  | Fax #: |  |
|  |  |  |  |
| **Please fax this completed form to: 208.625.4701.** Your patient will be contacted promptly. |
| Date patient contacted by Referral Coordinator: |  | KCCS Staff Use Only |
| Date of patient’s appointment at KCC: |  |
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