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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